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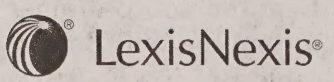

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TITLE 23

PUBLIC UTILITIES AND REGULATED INDUSTRIES

(CHAPTERS 1-29 IN VOLUME 22; CHAPTERS 30-59 IN VOLUME 23A; CHAPTERS 60-73 IN VOLUME 23B; CHAPTERS 88-117 IN VOLUME 24B)

SUBTITLE 3. INSURANCE (CONT'D)

CHAPTER.

SUBTITLE 3. INSURANCE (CONT'D)

CHAPTER 75

HOSPITAL AND MEDICAL SERVICE CORPORATIONS

SECTION.

23-75-111. Subscription contracts.

(a)(1) All rates charged by the corporation to subscribers or classes of subscribers having contracts covered by §§ 23-85-101 — 23-85-131, and the form and content of all contracts between the corporation and its subscribers, classes of subscribers, or groups of subscribers, and the certificates issued by the corporation representing their subscribers' agreements shall be subject at all times to the prior approval of the Insurance Commissioner.

(2) Application for approval shall be made to the commissioner in such form and shall set forth such information as the commissioner may require.

(3) Rates shall not be excessive, inadequate, or unfairly discriminatory in relation to the services offered.

(4)(A) Upon the commissioner's review of an application at any time, if the applicant requests a hearing, the commissioner shall hold a hearing before issuing an order of disapproval. The applicant shall be given not less than ten (10) days' written notice of the hearing. The notice shall specify the matters to be considered at the hearing.

(B) If after the hearing provided by subdivision (a)(4)(A) of this section the commissioner finds that the application or a part thereof does not meet the requirements of this code, the commissioner shall issue an order specifying in what respects he or she finds that it fails. Notice thereof shall immediately be served on the applicant, either personally or by mail. Within thirty (30) days after the date of such a notice, the applicant may apply to the Pulaski County Circuit Court to show cause why the action of the commissioner should be set aside and the application approved.

(b)(1) In any hospital service corporation contract, any medical service corporation contract, or any hospital and medical service corporation contract, whether group or individual, that contains a provision whereby coverage of a dependent in a family group terminates at a specified age, there shall also be a provision that coverage of an unmarried dependent who is incapable of sustaining employment by reason of intellectual and developmental disability or physical disability, who became so incapacitated prior to the attainment of nineteen (19) years of age and who is chiefly dependent upon the contract holder or certificate holder for support and maintenance, shall not terminate, but coverage shall continue so long as the contract or certificate remains in force and so long as the dependent remains in such a condition.

(2) At the request and expense of the corporation, proof of the incapacity and dependency must be furnished to the corporation by the contract or certificate holder at least thirty-one (31) days before the child's attainment of the limiting age, and, subsequently, as may be required by the corporation, but not more frequently than annually, after the two-year period following the child's attainment of the limiting age.

(c)(1) Each contract shall plainly state the services to which the subscriber is entitled and those to which the subscriber is not entitled under the plan.

(2) As to benefits provided on a service, instead of cash indemnity basis, the contract shall constitute a direct obligation of the hospitals and physicians with which or with whom the corporation has contracted for hospital or medical services.

(3) A copy of the contract shall be delivered to the subscriber.

(d)(1) The commissioner shall review filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this chapter.

(2) Each filing shall be on file for a waiting period of thirty (30) days before it becomes effective. The period may be extended by the commis-

sioner for an additional period not to exceed thirty (30) days if the commissioner gives written notice within the waiting period to the insurer which made the filing that the commissioner needs such additional time for the consideration of the filing.

(3) Upon written application by the insurer, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof.

(4) A filing shall be deemed to meet the requirements of this chapter unless disapproved by the commissioner within the waiting period or any extension thereof.

History. Acts 1959, No. 148, § 678; 1969, No. 263, § 5; 1971, No. 127, § 1; 1975, No. 404, § 4; 1975, No. 642, § 2; 1975, No. 649, § 4, 8; 1979, No. 906, § 1; 1983, No. 522, § 49; A.S.A. 1947, § 66-4908; Acts 1997, No. 208, § 25; 2005, No. 1962, § 108; 2019, No. 1035, § 50.

A.C.R.C. Notes. Acts 2017, No. 255, § 1, provided: "Legislative intent and purpose. The General Assembly hereby acknowledges that many of the laws relating to individuals with disabilities are antiquated, functionally outmoded, derogatory, and ambiguous or are inconsistent with more recently enacted provisions of the law. Consequently, it is the intent of the General Assembly and the purpose of this act to clarify the relevant chapters of Titles 1, 6, 9, 13, 14, 16, 17, 20, 22, 23, and 27 of the Arkansas Code of 1987 Annotated."

Amendments. The 2019 amendment substituted "intellectual and developmental disability" for "mental retardation" in (b)(1).

23-75-120. Tax exemptions.

(a) Every corporation doing business pursuant to this chapter is declared to be a nonprofit and benevolent institution.

(b) The corporations are exempt from state, county, district, municipal, and school tax, including the taxes prescribed by this code, and excepting only tax on net direct written premiums under § 23-75-119 and § 26-57-601 et seq. and applicable fees prescribed by § 23-61-401 and other sections of this code, or the Insurance Commissioner's rules applicable to hospital and medical service corporations, and taxes on real and tangible personal property situated in this state.

History. Acts 1959, No. 148, § 688; A.S.A. 1947, § 66-4918; Acts 1995, No. 408, § 2; 2019, No. 315, § 2696.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (b).

23-75-122. Conversion to legal reserve mutual life insurer.

(a) A hospital and medical service corporation, as defined in § 23-75-101, may be converted to a legal reserve mutual life insurer, as defined in § 23-69-102, under a plan or procedure which shall be approved by the order of the Insurance Commissioner.

(b) The commissioner shall approve any such plan or procedure if he or she finds that the plan:

(1) Would not be contrary to law and would not be contrary to the interests of subscribers or contract holders or to the public;

(2) Has been approved by the corporation in accordance with its articles of incorporation, bylaws, and with the law;

(3) Provides for definite conditions to be fulfilled by a designated early date upon which the mutualization will be deemed effective; and

(4) Provides for the protection of all existing contractual rights of the corporation's subscribers or contract holders for medical and hospital service or case or claims for reimbursement therefor, and for the mutualizing insurer to assume, without reincorporation, all assets and liabilities of the corporation.

(c) Upon conversion, the corporation will have the minimum surplus required of legal reserve mutual life insurers.

(d) Upon completion of its conversion to a legal reserve mutual life insurer as provided in this section, the corporation shall be subject to and comply with all laws and rules applicable to legal reserve mutual life insurers.

(e) The corporation shall have the period of time which shall be specified in the commissioner's order to complete its conversion to a legal reserve mutual life insurer.

History. Acts 1985, No. 997, §§ 1-3; A.S.A. 1947, §§ 66-4922 — 66-4924; Acts 2019, No. 315, § 2697.

Amendments. The 2019 amendment substituted "rules" for "regulations" in (d).

CHAPTER 76

HEALTH MAINTENANCE ORGANIZATIONS

23-76-103. Applicability of Arkansas Insurance Code and laws concerning hospital and medical service corporations.

(a)(1) Except as otherwise provided in this chapter, provisions of the insurance law and provisions of hospital and medical service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this chapter.

(2) Subdivision (a)(1) of this section shall not apply to an insurer or hospital and medical service corporation licensed and regulated pursuant to the insurance laws or the hospital and medical service corporation laws of this state, except with respect to its health maintenance

organization activities authorized and regulated pursuant to this chapter.

(b) The provisions of this chapter, the Arkansas Insurance Code, and the law concerning hospital and medical service corporations, § 23-75-101 et seq., shall not be applicable to any nonprofit vision service plan corporation composed of at least fifty (50) participating licensed optometrists or ophthalmologists licensed by the State of Arkansas to provide vision care services on a prepaid basis, when each licensed optometrist or ophthalmologist is subject to the rules of the professional's respective state board, and when each participating licensed optometrist or ophthalmologist agrees to assume responsibility for completion of the provisions of the vision care services contracted for, so that no element of risk is incurred by any subscriber group or person.

(c) This chapter does not apply to a:

(1) Health care sharing ministry as defined in § 23-60-104(b); or

(2) Direct primary care agreement as defined in § 23-60-104(b).

History. Acts 1975, No. 454, § 15; A.S.A. 1947, § 66-5215; Acts 1999, No. 881, § 10; 2001, No. 1605, § 1; 2013, No. 1163, § 2; 2015, No. 101, § 2; 2017, No. 1020, § 2; 2019, No. 315, § 2698.

Amendments. The 2015 amendment inserted designation (c)(1); and added (c)(2).

The 2017 amendment substituted "Direct primary care agreement" for "Concierge service arrangement" in (c)(2).

The 2019 amendment deleted "and regulations" following "rules" in (b).

23-76-104. Arkansas Insurance Code sections applicable to health maintenance organizations.

(a) Except to the extent that the Insurance Commissioner determines that the nature of health maintenance organizations, healthcare plans, and evidences of coverage render such sections clearly inappropriate, the following sections are applicable to health maintenance organizations:

(1) Sections 23-60-101 — 23-60-108 and 23-60-110, referring to scope of the Arkansas Insurance Code;

(2) Section 23-61-101 et seq., § 23-61-201 et seq., and § 23-61-301 et seq., referring to the Insurance Commissioner;

(3) Sections 23-63-102 — 23-63-104, § 23-63-201 et seq., general provisions, and § 23-63-301 et seq., referring to service of process, a registered agent as process agent, serving legal process, and time to plead;

(4) Section 23-63-601 et seq., referring to assets and liabilities, and § 23-63-901 et seq., referring to administration of deposits;

(5) Section 23-63-1501 et seq., referring to risk-based capital requirements;

(6) Section 23-64-101 et seq., § 23-64-201 et seq., and § 23-64-501 et seq., referring to agents, brokers, solicitors, and adjusters;

(7) The Trade Practices Act, § 23-66-201 et seq.; §§ 23-66-301 — 23-66-306 and 23-66-308 — 23-66-314; and § 23-66-501 et seq., referring to trade practices and frauds;

(8) Section 23-68-101 et seq., referring to rehabilitation and liquidation;

(9) Section 23-69-134, referring to home office and records and the penalty for unlawful removal of records;

(10) Section 23-69-156, referring to extinguishing unused corporate charters;

(11) Sections 23-75-104, 23-75-105, and 23-75-116, referring to hospital and medical service corporations;

(12) Sections 23-79-101 — 23-79-107, 23-79-109 — 23-79-128, 23-79-131 — 23-79-134, and 23-79-202 — 23-79-210, referring to insurance contracts;

(13) Sections 23-85-101 — 23-85-132, 23-85-134, and 23-85-136, referring to individual accident and health insurance;

(14) Sections 23-86-101 — 23-86-104, 23-86-106, 23-86-108 — 23-86-111, 23-86-113 — 23-86-117, 23-86-119, 23-86-120, § 23-86-201 et seq., § 23-86-301 et seq., and § 23-86-401 et seq., referring to blanket and group accident and health insurance;

(15) Section 23-99-201 et seq., § 23-99-301 et seq., § 23-99-401 et seq., § 23-99-501 et seq., § 23-99-601 et seq., and § 23-99-701 et seq., referring to healthcare providers;

(16) Section 23-64-515, referring to notice of termination of appointment; and

(17) The Arkansas Life and Health Insurance Guaranty Association Act, § 23-96-101 et seq., referring to the Arkansas Life and Health Insurance Guaranty Association.

(b)(1) A health maintenance organization domiciled or applying to be domiciled in this state may elect to be subject to the Insurance Holding Company Regulatory Act, § 23-63-501 et seq., by:

(A) Written notice in its application at the time the health maintenance organization applies to be domiciled in Arkansas; or

(B) Providing thirty (30) days' prior written notice to the commissioner if the health maintenance organization was domiciled in Arkansas on March 22, 2007.

(2) An election under this subsection:

(A) Shall not be revoked;

(B) Requires that if a modification is required to be reported or filed under the Insurance Holding Company Regulatory Act, § 23-63-501 et seq., the health maintenance organization shall comply with the provisions concerning notice of major modifications to the operation of the health maintenance organization under the Insurance Holding Company Regulatory Act, § 23-63-501 et seq., instead of the provisions concerning notice of major modifications to the operation of the health maintenance organization under § 23-76-107(d); and

(C) Does not affect the duty of a health maintenance organization to make any other filing required under § 23-76-107(d) that is not

required by the Insurance Holding Company Regulatory Act, § 23-63-501 et seq.

(c) If a health maintenance organization does not elect to be subject to the Insurance Holding Company Regulatory Act, § 23-63-501 et seq., it shall be subject to § 23-69-142 regarding mergers, consolidations, and acquisitions.

History. Acts 1975, No. 454, § 25; 1983, No. 624, § 2; A.S.A. 1947, § 66-5225; Acts 1999, No. 624, § 3; 2001, No. 1605, § 2; 2007, No. 429, § 2; 2011, No. 760, § 13; 2013, No. 355, § 11; 2017, No. 283, § 17; 2019, No. 520, § 1.

Amendments. The 2017 amendment substituted "The Trade Practices Act, § 23-66-201 et seq.; §§ 23-66-301 — 23-66-306 and 23-66-308 — 23-66-314; and § 23-66-501 et seq." for "Section 23-66-201 et seq., §§ 23-66-301 — 23-66-306, and 23-66-308 — 23-66-314" in (a)(7).

The 2019 amendment added (a)(17).

23-76-107. Establishment.

(a)(1) Any person that meets the requirements of § 23-76-102(9) may apply to the Insurance Commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization.

(2) No person shall establish or operate a health maintenance organization in this state, nor sell or offer to sell, nor solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization without obtaining a certificate of authority under this chapter.

(3) The corporation must have the express authority to operate a health maintenance organization contained in its articles of incorporation. Incorporation shall not be required of any entity that has been issued a certificate of authority prior to March 30, 1987.

(b)(1) Every health maintenance organization, as of July 9, 1975, shall submit an application for a certificate of authority under subsection (c) of this section within sixty (60) days of July 9, 1975.

(2) Each applicant may continue to operate until the commissioner acts upon the application.

(3) In the event that an application is denied under § 23-76-108, the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked.

(c) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner, and shall set forth or be accompanied by the following:

(1) A copy of the basic organizational document, if any, of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees,

executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(4) A copy of any contract made or to be made between any providers or persons listed in subdivision (c)(3) of this section and the applicant;

(5) A statement generally describing the health maintenance organization, its healthcare plans, facilities, and personnel;

(6) A copy of the form of evidence of coverage to be issued to the enrollees;

(7) A copy of the form of the group contract, if any, that is to be issued to employers, unions, trustees, or other organizations;

(8)(A) Financial statements showing the applicant's assets, liabilities, and sources of financial support.

(B) If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the commissioner directs that additional or more recent financial information is required for the proper administration of this chapter;

(9) A financial feasibility plan that includes:

(A) Detailed enrollment projections;

(B) The methodology for determining premium rates to be charged during the first twelve (12) months of operation certified by an actuary or other qualified person;

(C) A projection of balance sheets;

(D) Cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state, and income and expense statements anticipated from the start of operations until the health maintenance organization has had net income for at least one (1) year; and

(E) A statement as to the source of working capital as well as any other sources of funds;

(10)(A) On and after January 1, 2003, a power of attorney executed by the applicant, if not domiciled in this state, and filed, along with a proper fee specified by the commissioner, with the commissioner's office to register an Arkansas resident to serve as the true and lawful attorney of the applicant in and for this state upon whom may be served all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state.

(B) In the event no registered agent has been chosen, the commissioner may be served until the appointment of an Arkansas-registered agent for service of process has been entered upon the records of the commissioner;

(11) A statement or map reasonably describing the geographic areas to be served;

(12) A description of the complaint procedures to be utilized as required under § 23-76-116;

(13) A description of the procedures and programs to be implemented to meet the quality of healthcare requirements in § 23-76-108;

(14) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under § 23-76-110(b);

(15) A list of the names and addresses of all providers with which the health maintenance organization has agreements; and

(16) Such other information as the commissioner may require to make the determinations required in § 23-76-108.

(d)(1) A health maintenance organization shall file a notice describing any major modification of the operation set out in the information required by subsection (c) of this section unless otherwise provided for in this chapter. The notice shall be filed with the commissioner prior to the modification. If the commissioner does not disapprove within sixty (60) days of filing, the modification shall be deemed approved.

(2) The commissioner shall promulgate rules exempting from the filing requirements of subdivision (c)(1) of this section those items the commissioner deems unnecessary.

History. Acts 1975, No. 454, § 3; A.S.A. 1947, § 66-5203; Acts 1987, No. 456, § 22; 1993, No. 901, § 35; 2001, No. 1605, § 3; 2013, No. 1433, § 2; 2019, No. 315, §§ 2699, 2700.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (c)(2) and (d)(2).

23-76-109. Powers — Definition.

(a) The powers of a health maintenance organization include, but are not limited to, the following:

(1) The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and the property as may reasonably be required for its principal office or for other purposes as may be necessary in the transaction of the business of the health maintenance organization;

(2) The making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing healthcare services to enrollees;

(3) The furnishing of healthcare services through providers which are under contract with the health maintenance organization;

(4) The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment, and administration;

(5) The contracting with an insurance company licensed in this state, or with a hospital or medical service corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of healthcare services provided by the health maintenance organization;

(6) The offering, in addition to basic healthcare services, of:

(A) Additional healthcare services;

(B) Indemnity benefits covering out-of-area or emergency services, and special services not provided on a direct service basis; and

(C)(i) Indemnity benefits on a point-of-service basis within such limits as may be prescribed by the Insurance Commissioner.

(ii) As used in this section, the term "point-of-service" means indemnifying or paying on behalf of an enrollee for covered health-care services on a nonemergency, self-referred basis obtained from providers who are not employed by, under contract with, or otherwise affiliated with, the health maintenance organization, or services obtained from providers affiliated with the health maintenance organization without proper referrals; and

(7) The contracting with providers located out of state who are properly licensed to render medical care in the jurisdiction in which such a provider is located.

(b)(1)(A) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner prior to each exercise of any power granted in subdivision (a)(1) or subdivision (a)(2) of this section.

(B) The commissioner shall disapprove the exercise of power if in his or her opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations.

(C) If the commissioner does not disapprove within sixty (60) days of the filing, the exercise of power shall be deemed approved.

(2) The commissioner may promulgate rules exempting from the filing requirement of subdivision (b)(1) of this section those activities having a de minimis effect.

History. Acts 1975, No. 454, § 5; A.S.A. 1947, § 66-5205; Acts 1995, No. 1272, § 16; 1999, No. 881, § 11; 2019, No. 315, § 2701.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (b)(2).

23-76-119. Prohibited practices — Definition.

(a) No health maintenance organization, or representative thereof, may knowingly cause or knowingly permit the use of advertising that is untrue or misleading, solicitation that is untrue or misleading, or any form of evidence of coverage that is deceptive. For purposes of this chapter:

(1) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect that is or may be significant to an enrollee of, or person considering enrollment in, a healthcare plan;

(2) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding healthcare coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible

significance to an enrollee of, or person considering enrollment in, a healthcare plan, if the benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist; and

(3) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding healthcare plans and evidences of coverage therefor, to expect benefits, services, charges, or other advantages that the evidence of coverage does not provide or that the healthcare plan issuing the evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

(b) An enrollee may not be cancelled or nonrenewed except for the failure to pay the charge for the coverage or for such other reasons as may be promulgated by the Insurance Commissioner.

(c) HOLD HARMLESS.

(1) Every contract between a health maintenance organization and a participating provider of healthcare services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for healthcare services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the health maintenance organization.

(2) In the event that the participating provider contract has not been reduced to writing as required by this subsection or that the contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization.

(3)(A) No participating provider or the provider's agent, trustee, or assignee may maintain an action at law against a subscriber or enrollee to collect sums owed to them by the health maintenance organization nor shall they make any statement, either written or oral, to any subscriber or enrollee that makes demand for, or would lead a reasonable person to believe that a demand is being made for, payment of any amounts owed by the health maintenance organization.

(B)(i) If a participating provider has a pattern or practice of violating this subsection and continues to violate this subsection after the commissioner has issued a written warning to the participating provider, the commissioner may levy a penalty in an amount not less than one hundred fifty dollars ($150) nor more than one thousand five hundred dollars ($1,500).

(ii) Before imposing the penalty, the commissioner shall send a written notice to the participating provider informing the provider of the right to a hearing pursuant to §§ 23-61-303 — 23-61-307.

(4) "Participating provider" means a "provider" as defined in § 23-76-102(10) who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide healthcare services to enrollees with an expectation of

receiving payment, other than copayment or deductible, directly or indirectly, from the health maintenance organization.

(d)(1) A health maintenance organization or its contractor or subcontractor may pay a claim for healthcare services by any lawful method, including the alternative payment method by gift card, credit card, or other type of electronic payment or virtual credit card as payment if the healthcare provider is given clear instructions about how to select the alternative payment method.

(2) However, a health maintenance organization or its contractor or subcontractor is prohibited from requiring a participating provider to accept a gift card, credit card, or other type of electronic payment or virtual credit card as payment of a claim for healthcare services if the method of payment charges the participating provider a service fee to process.

History. Acts 1975, No. 454, § 15; A.S.A. 1947, § 66-5215; Acts 2001, No. 1702, § 2; 2019, No. 300, § 1.

Amendments. The 2019 amendment added (d).

23-76-120. Regulation of agents — Definition.

(a) After notice and hearing, the Insurance Commissioner may promulgate such reasonable rules as are necessary to provide for the licensing of agents.

(b) "Agent" means a person directly or indirectly associated with a healthcare plan who engages in solicitation or enrollment.

History. Acts 1975, No. 454, § 16; A.S.A. 1947, § 66-5216; Acts 2019, No. 315, § 2702.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (a).

23-76-125. Rules.

(a) After notice and hearing, the Insurance Commissioner may promulgate reasonable rules, not inconsistent with existing statutes of this state, as are necessary or proper to carry out the provisions of this chapter.

(b) The rules shall be subject to review in accordance with § 23-61-307.

History. Acts 1975, No. 454, § 21; A.S.A. 1947, § 66-5221; Acts 2019, No. 315, § 2703.

Amendments. The 2019 amendment substituted "Rule" for "Regulations" in the section heading; and deleted "and regulations" following "rules" in (a) and (b).

CHAPTER 77

AUTOMOBILE CLUBS OR ASSOCIATIONS

SECTION.

23-77-103. Penalty.

(a) It shall be unlawful for any person, firm, association, copartnership, corporation, company, or other organization to organize, operate, or in any way solicit members for an automobile club or association or offer any of the motor club services as defined in § 23-77-101, except in the manner provided in this chapter and under the rules promulgated by the Insurance Commissioner.

(b) Any person, firm, association, copartnership, corporation, company, or other organization violating the provisions of this section shall be guilty of a Class A misdemeanor.

History. Acts 1955, No. 377, § 7; A.S.A. 1947, § 75-1607; Acts 2005, No. 1994, § 357; 2019, No. 315, § 2704.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (a).

23-77-105. Authority of Insurance Commissioner to grant certificates of authority and conduct hearings.

(a)(1) The Insurance Commissioner shall have full and complete authority to grant certificates of authority to automobile clubs or associations, to revoke the certificates, and to prescribe such rules as are reasonably necessary for the conduct of the business of the automobile clubs or associations within the state and for carrying out the objects and purposes of this chapter.

(2) In determining if a certificate of authority shall be issued, the commissioner shall take into consideration, along with all other factors, the name of the automobile club or association. If the name will interfere with the transactions of an automobile club or association already doing business in this state or is so similar to one already appropriated as to confuse or likely to mislead the public in any respect, the commissioner shall refuse to issue a certificate of authority.

(b) The commissioner shall also have authority to conduct hearings as now provided under the insurance laws of the state.

History. Acts 1955, No. 377, § 3; A.S.A. 1947, § 75-1603; Acts 2019, No. 315, § 2705.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (a)(1).

CHAPTER 78

BURIAL ASSOCIATIONS

A.C.R.C. Notes. Acts 2017, No. 788, § 1, provided: "Abolition of the Arkansas Cemetery Board, the State Board of Embalmers and Funeral Directors, and the Burial Association Board.

"(a) The Arkansas Cemetery Board, State Board of Embalmers and Funeral Directors, and Burial Association Board are abolished, and their powers, duties, functions, records, personnel, property, unexpended balances of appropriations, allocations, or other funds are transferred to the State Insurance Department by a type 3 transfer under § 25-2-106.

"(b)(1) For the purposes of this act, the State Insurance Department shall be considered a principal department established by Acts 1971, No. 38.

"(2) All rules promulgated by the Arkansas Cemetery Board, the State Board of Embalmers and Funeral Directors, and the Burial Association Board in effect before the effective date of this act [July 1, 2018], are transferred as a matter of law to the State Insurance Department on the effective date of this act [July 1, 2018] and shall be considered an officially promulgated rule of the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services of the State Insurance Department."

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-101. Definitions.

As used in this chapter:

(1) "Association" or "burial association" means:

(A) Any person, firm, association, copartnership, corporation, company, or other organization which, from and after February 18, 1953:

(i) Undertakes for consideration paid by or on behalf of its members to defray all or a part of the funeral expenses of the members;

(ii) Furnishes or undertakes to furnish merchandise, supplies, and services or any other character of burial benefits to the members; or

(iii) Issues a certificate which provides for the payment of funeral benefits to the members in services, merchandise, or supplies, including the services of funeral directors and embalmers; and

(B) Every person, firm, association, copartnership, corporation, or company which, prior to February 18, 1953, has:

(i) Undertaken for a consideration to pay money to its contributors for the purposes of defraying all or part of the funeral expenses of a deceased person;

(ii) Furnished or has undertaken to furnish supplies and services or any other character of burial benefits to the contributing person or to his or her beneficiaries or members of his or her family; or

(iii) Issued any form of contract or certificate which, under its terms, provides for the payment of funeral benefits in money, services, or supplies, including the services of undertakers or embalmers; and

(2) [Repealed.]

History. Acts 1953, No. 91, §§ 1, 2; 1985, No. 679, § 1; A.S.A. 1947, §§ 66-1801, 66-1802; Acts 2017, No. 788, § 67.

Amendments. The 2017 amendment repealed former (2).

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-102. Applicability.

(a)(1) All burial associations organized or operating in the State of Arkansas as of February 18, 1953, shall be deemed in all respects to be organized or operating exclusively under the provisions of this chapter, and to have authority from the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services to engage in their business.

(2) A burial association under subdivision (a)(1) of this section shall be subject to the supervision, authority, and control of the board and subject to all the provisions of this chapter.

(b) All burial associations organized in this state from and after February 18, 1953, shall organize exclusively under the provisions of this chapter and shall be subject to the authority, control, and supervision of the board and to all of the provisions of this chapter.

History. Acts 1953, No. 91, § 7; A.S.A. 1947, § 66-1807; Acts 2017, No. 788, § 68.

Amendments. The 2017 amendment redesignated former (a) as present (a)(1) and (a)(2); substituted "State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "Burial Association Board" in (a)(1); and substituted "A burial association under subdivision (a)(1) of this section" for "They" in (a)(2).

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-104. Penalty.

(a) A person, firm, association, copartnership, corporation, company, or other organization shall not organize, operate, or in any way solicit

members for a burial association, or for participation in any plan, scheme, or device similar to burial associations, except in the manner provided by this chapter and the rules promulgated by the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services.

(b) Any person, firm, association, copartnership, corporation, company, or other organization violating the provisions of this section shall be guilty of a Class A misdemeanor.

History. Acts 1953, No. 91, § 16; A.S.A. 1947, § 66-1816; Acts 2005, No. 1802, § 1; 2005, No. 1994, § 358; 2017, No. 788, § 69.

Amendments. The 2017 amendment, in (a), substituted "A" for "It shall be unlawful for any" and "shall not organize" for "to organize", deleted "and regulations" following "the rules", and substituted "State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "Burial Association Board".

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-105. [Repealed.]

Publisher's Notes. This section, concerning the burial association board creation and members, was repealed by Acts 2017, No. 788, § 70, effective July 1, 2018.

23-78-106. [Repealed.]

Publisher's Notes. This section, concerning the burial association board proceedings, was repealed by Acts 2017, No. 788, § 71, effective July 1, 2018.

23-78-107. [Repealed.]

Publisher's Notes. This section, concerning the burial association board office and employees, was repealed by Acts 2017, No. 788, § 72, effective July 1, 2018.

23-78-108. [Repealed.]

Publisher's Notes. This section, concerning burial association board powers and duties, was repealed by Acts 2017, No. 788, § 73, effective July 1, 2018.

23-78-109. Burial associations under authority, supervision, and control of board.

All burial associations organized or operating in the State of Arkansas are under the authority, supervision, and control of the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services.

History. Acts 1953, No. 91, § 6; A.S.A. 1947, § 66-1806; Acts 2017, No. 788, § 74.

Amendments. The 2017 amendment substituted "are under" for "shall be under" and "State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "Burial Association Board".

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-110. Certificate of authority.

(a) Applications for a certificate of authority shall be on forms furnished by the State Board of Embalmers, Funeral Directors, Cem-

eteries, and Burial Services, and a burial association shall not begin operation until the application has been approved and the certificate of authority has been granted by the board.

(b) The following documents and information shall be filed with the application for a certificate of authority:

(1) Consent to service of process upon the secretary of the applicant;

(2) A copy of the proposed form of membership application, membership certificate, bylaws, and contracts for service, merchandise, supplies, and any other data requested by the board;

(3) References as to character, ability, and integrity of the organizers and of any funeral director or embalmer with whom the applicant proposes to contract;

(4) An application fee as determined by rule of the board; and

(5)(A) Proof of a deposit to the association's mortuary funds in an amount determined by rule of the board.

(B) The deposit required under subdivision (b)(5)(A) of this section shall not exceed ten thousand dollars ($10,000).

(c) If the board is satisfied that the applicant is qualified and meets the requirements of this chapter, the board shall issue to the applicant a certificate of authority.

History. Acts 1953, No. 91, § 8; A.S.A. 1947, § 66-1808; Acts 2007, No. 583, § 1; 2011, No. 875, § 2; 2017, No. 788, § 75.

Amendments. The 2017 amendment, in (a), substituted "State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "Burial Association Board", "a burial association shall not" for "no burial association shall", "has been approved" for "shall have been approved", and "has been granted" for "shall have been granted".

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-111. Fees — Oath at payment.

(a)(1) In order to meet the expense of supervision and of carrying out the other provisions of this chapter, the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services may set license fees for burial associations subject to its jurisdiction as set forth in § 23-78-109.

(2) The board shall collect the annual license fee from each burial association that is operating and in good standing on or before February 15 of the year in which the license fee is payable.

(b)(1) The fee shall be due and payable to the board not later than February 1 of each year, and upon payment of the fee, the board shall issue to each burial association a license that shall entitle the association to do business in the State of Arkansas during the calendar year for which the license is issued.

(2) If the license fee for any year is not paid within thirty (30) days from the date upon which it is due, the board may revoke and cancel the authorization of the delinquent burial association to transact business in the State of Arkansas.

(c) It shall be the duty of every burial association to certify under oath at the time of the payment of the license fee the true and correct

membership of the burial association on January 1 of the applicable year.

(d) If any officer or agent of any burial association knowingly makes any false statement with respect to the information required by this section to be furnished, he or she shall be guilty of a Class A misdemeanor.

(e) The board shall have and is given the power and authority to reduce or increase, temporarily or permanently, the fees set forth in subsection (a) of this section if the board deems such an action advisable.

History. Acts 1953, No. 91, § 14; 1973, No. 515, § 1; 1975, No. 380, § 1; 1979, No. 244, § 1; 1981, No. 494, § 2; 1983, No. 784, § 2; 1985, No. 480, § 1; A.S.A. 1947, § 66-1814; Acts 1989, No. 344, § 1; 1995, No. 485, § 1; 2005, No. 1994, § 457; 2009, No. 552, § 1; 2011, No. 875, § 3; 2017, No. 788, § 76.

Amendments. The 2017 amendment substituted "State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "Burial Association Board" in (a)(1).

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-113. Agent's license required.

(a) Before an agent or representative represents a burial association in this state, the agent or representative shall first apply to the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services for a license.

(b)(1) The board shall have full power and authority to issue the license upon proof satisfactory to the board that the person is capable of soliciting burial association memberships and is of good moral character and recommended by the association in behalf of which the membership solicitations are to be made.

(2) The board may reject the application of any person who does not meet the requirements herein set out.

(c) The board may revoke the license upon proof satisfactory to it that the licensed agent has violated any section of this chapter.

(d) The license fee shall be ten dollars ($10.00), and the license must be renewed for each calendar year at the same fee.

(e) It shall not be necessary that the president, vice president, or the secretary-treasurer of any burial association obtain a license for soliciting memberships in any association of which the person is president, vice president, or secretary-treasurer.

(f) Membership certificates shall not be issued by a solicitor in the field, but all applications shall be forwarded to the office of the association, and the certificates shall be issued there and a record made of the issuance at the time the certificate is issued.

History. Acts 1953, No. 91, § 13; 1981, No. 494, § 1; A.S.A. 1947, § 66-1813; Acts 2017, No. 788, § 77.

Amendments. The 2017 amendment, in (a), substituted "Before an agent" for "Before any agent", "represents a" for "shall or may represent any", "the agent or representative" for "he or she", and "State

Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "Burial Association Board".

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-115. Rules and bylaws.

All burial associations shall have and maintain rules and bylaws in such form and with such contents as prescribed by the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services.

History. Acts 1953, No. 91, § 9; A.S.A. 1947, § 66-1809; Acts 2017, No. 788, § 78.

Amendments. The 2017 amendment substituted "prescribed by the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "shall be prescribed by the Burial Association Board".

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-116. Membership dues and assessments.

(a) From and after February 18, 1953, a burial association organized or operating in this state shall not issue a certificate providing benefits for a member for an assessment or membership dues less than the minimum assessment or minimum dues prescribed for the benefits by the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services.

(b) However, dues and assessments of the membership as of February 18, 1953, shall not be changed by the board.

History. Acts 1953, No. 91, § 11; A.S.A. 1947, § 66-1811; Acts 2017, No. 788, § 79.

Amendments. The 2017 amendment, in (a), substituted "a burial association" for "no burial association", "shall not issue a certificate" for "shall issue any certificate", and "State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "Burial Association Board".

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-117. Books, records, accounts, and documents — Inspection and audit.

(a) The books, records, accounts, and documents of all burial associations organized or operating in this state shall at all times be open for inspection, examination, and audit by the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services, its agents and employees.

(b)(1) Through its agents and employees, the board shall make examinations, from time to time, of all burial associations.

(2)(A) If, at the time of an examination or audit, the board determines that a burial association's books, records, accounts, and documents are insufficient, unavailable, or in no condition to be examined or audited, the board may collect a fee not to exceed one thousand dollars ($1,000) and recover costs incurred, including the following:

(i) Round trip mileage from the board office to the burial association, at the travel rate then prevailing for other state employees; and

(ii) Per diem expenses at the travel rate then prevailing for other state employees.

(B) Any fees or costs incurred shall not be payable from the burial association's mortuary fund.

(c) The board shall be audited from time to time by the Legislative Joint Auditing Committee.

History. Acts 1953, No. 91, § 12; 1981, No. 360, § 2; A.S.A. 1947, § 66-1812; Acts 1995, No. 485, § 2; 2017, No. 788, § 80.

Amendments. The 2017 amendment substituted "State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "Burial Association Board" in (a).

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-118. Books — False entries prohibited.

A person or burial association official who knowingly makes or allows to be made a false entry on the books of the association with intent to deceive or defraud a member of the association or with intent to conceal the true condition of the association from the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services or its agents or employees or any auditor authorized to examine the books of the association under the supervision of the board is guilty of a Class A misdemeanor.

History. Acts 1953, No. 91, § 19; A.S.A. 1947, § 66-1819; Acts 2005, No. 1994, § 360; 2017, No. 788, § 81.

Amendments. The 2017 amendment substituted "A person" for "Any person", "a false entry" for "any false entry", "a member" for "any member", "State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "Burial Association Board", and "is guilty" for "shall be guilty".

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-119. Records — Failure to maintain.

(a) A burial association secretary or secretary-treasurer who fails to maintain records to the minimum standards required by the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services shall be removed by the board from office and another elected by the association in his or her stead.

(b) The election shall be immediately upon notice of the removal.

History. Acts 1953, No. 91, § 20; A.S.A. 1947, § 66-1820; Acts 2017, No. 788, § 82.

Amendments. The 2017 amendment, in (a), substituted "A" for "Any" and "State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "Burial Association Board".

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-120. Semiannual reports.

(a)(1) Using forms provided by the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services, each burial association or society licensed in this state shall file a semiannual report

showing the actual financial condition of the burial association or society as of June 30 and December 31 of each year.

(2) The report shall include documents and information as required by rule of the board.

(b)(1)(A) The report required under this section is due as of June 30 and December 31 each year.

(B) A report is delinquent if:

(i) It is due as of June 30, and it is filed with the board after August 15 of the year it is due; or

(ii) It is due as of December 31, and it is filed with the board after February 15 of the year next following the year it is due.

(2) If a due date under subdivision (b)(1) of this section falls on a weekend or holiday, the report shall be due on the first business day following the weekend or holiday.

(3)(A) The board may grant an extension of time to submit a report for good cause.

(B) A burial association or society shall file a request for an extension to the board in writing before the due date of the report.

(4)(A) A report submitted to the board that omits required documents or information shall not be considered as filed with the board and will be returned to the burial association or society for corrections or completion.

(B) A report that omits required documents or information is delinquent if the submission of documents or information to complete the report:

(i) Causes a report that is due as of June 30 to be filed with the board after August 15 of the year it is due; or

(ii) Causes a report that is due as of December 31 to be filed with the board after February 15 of the year next following the year it is due.

(5) A burial association or society whose report is delinquent is subject to a financial penalty established by rule of the board.

(c) The board shall recover costs incurred in conducting audits and preparing the semiannual report from those associations which fail to file the report prior to the expiration of the deadline referred to in subsection (b) of this section. Costs to be recouped shall include:

(1) Round-trip mileage from the board's office to the association, at the rate then prevailing for other state employees engaged in travel;

(2) Per diem expenses at the rate then prevailing for other state employees engaged in travel;

(3) Plus a two-hundred-fifty-dollar fee for preparing the report.

History. Acts 1953, No. 91, § 14; 1985, No. 480, § 2; A.S.A. 1947, § 66-1814; Acts 2011, No. 875, § 4; 2017, No. 788, § 83.

Amendments. The 2017 amendment substituted "State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "Burial Association Board" in (a)(1).

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-121. Rules.

(a) The State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services shall make and promulgate reasonable rules for the administration of this chapter and for the purpose of carrying out the intent of this chapter.

(b) The rules promulgated under subsection (a) of this section have the full force and effect of statute.

History. Acts 1953, No. 91, § 23; A.S.A. 1947, § 66-1823; Acts 2017, No. 788, § 84.

Amendments. The 2017 amendment redesignated the existing language as (a) and (b); in (a), substituted "State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "Burial Association Board", deleted "and regulations" following "rules" and "the provisions of" preceding "this chapter" and substituted "of this chapter" for "thereof"; and substituted "promulgated under subsection (a) of this section" for "and regulations shall" in (b).

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-122. Disposition of collections.

(a)(1)(A) Seventy-five percent (75%) of the collections of any burial association or society shall be solely for the payment of benefits provided by membership certificates and shall not be used for the payment of operating expenses.

(B) The annual license fee shall not be considered an operating expense, and the annual license fee may be paid from the mortuary fund.

(2) However, subject to the reserve requirements established by the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services, the association or society may invest any portion of the seventy-five percent (75%) of the collections not needed for the immediate payment of benefits or not needed for the reasonably anticipated payment of benefits in:

(A) United States Treasury bonds, direct or indirect obligations of the United States Government;

(B) Bonds, notes, debentures, or other obligations issued by an agency of the United States Government, the principal and interest of which are fully guaranteed by the United States Government, and mortgages on real estate which are fully guaranteed as to principal and interest by the United States Government or agency thereof;

(C)(i) Preferred stocks of corporations created or existing under the laws of the United States or any state thereof.

(ii) However, the funds shall be invested only in preferred stocks designated as "A" rated or the equivalent by one (1) or more nationally recognized investment services, and approved by the board.

(iii) Further, no more than fifteen percent (15%) of the total funds of any burial association or society available for investment shall be invested in preferred stocks;

(D)(i) Certificates of deposit of any state or national bank in Arkansas which are insured by the Federal Deposit Insurance Corporation.

(ii)*(a)* However, if the certificates of deposit issued by the bank exceed the amount of the certificates of deposit insured by the Federal Deposit Insurance Corporation, the bank shall furnish to the association or secretary and the board or the Insurance Commissioner evidence of the assignment of bonds or other securities issued by the State of Arkansas or the United States to secure the payment of the certificates.

(b) This may be done by making the assignment through a federal reserve bank or through a correspondent bank.

(c) In the alternative, the issuing bank may make such assignment in such other form or manner as may be approved by the board or the executive secretary;

(E)(i) Savings accounts of any savings and loan association which are insured by the Federal Deposit Insurance Corporation.

(ii)*(a)* However, if the savings account of the association exceeds the amount of the savings account insured by the Federal Deposit Insurance Corporation, the association shall furnish to the depositing burial association or secretary and the board or the executive secretary evidence of the assignment of bonds, or other securities issued by the State of Arkansas or the United States, to secure payment of the accounts.

(b) The savings and loan association in which the accounts exist shall make the assignment in a form and manner approved by the board or the commissioner;

(F) "A" rated or better corporate bonds, as designated by one (1) or more nationally recognized investment services; or

(G)(i) "A" rated state and municipal bonds as designated by one (1) or more nationally recognized investment services.

(ii) However, the bonds must be issued by governmental entities in the State of Arkansas, and no more than thirty percent (30%) of the total funds of any burial association or society available for investment shall be invested in state or municipal bonds.

(b) Seventy-five percent (75%) of the interest derived from the investments shall also not be usable for the payment of operating expenses.

History. Acts 1953, No. 91, § 14; 1973, No. 515, § 1; 1975, No. 380, § 1; 1977, No. 861, § 1; 1981, No. 360, § 3; 1985, No. 679, § 4; A.S.A. 1947, § 66-1814; Acts 1987, No. 443, § 3; 2017, No. 788, §§ 85-87.

Amendments. The 2017 amendment substituted "State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "Burial Association Board" in the introductory language of (a)(2); in (a)(2)(D)(ii)*(a)*, deleted "shall" preceding "exceed the amount" and substituted "Insurance Commissioner" for "Executive Secretary of the Burial Association Board" and substituted "Insurance Commissioner" for "executive secretary" in (a)(2)(E)(ii)*(b)*.

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-123. Disposition of fees and charges.

(a)(1) All fees and charges collected by the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services under this chapter shall be deposited into a cash fund deposited to the State Treasury.

(2) The board is empowered to expend the funds for the requirements, purposes, and expenses of the board under the provisions of this chapter, upon a voucher approved by the board and signed by the Insurance Commissioner or his or her designee, provided that the total expense for every purpose incurred shall not exceed the total fees and charges collected by the board under the provisions of this chapter.

(b) The operation of the board and the carrying out of the functions set out in this chapter shall be at no expense to the State of Arkansas.

History. Acts 1953, No. 91, § 15; A.S.A. 1947, § 66-1815; Acts 2017, No. 788, § 88.

Amendments. The 2017 amendment, in (a)(1), substituted "State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "Burial Association Board", deleted "the provisions of" preceding "this chapter" and "in insured banks" following "deposited", and substituted "cash fund deposited to the State Treasury" for "fund to be known as the 'Burial Association Board Fund'"; and, in (a)(2), inserted "approved by the board and" and substituted "Insurance Commissioner or his or her designee" for "Executive Secretary of the Burial Association Board".

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-124. Revocation of certificate, license, charter, etc. — Hearing.

(a) Before revoking a certificate of authority or license granted under this chapter or any charter or other authority granted to a burial association under any law effective before February 18, 1953, the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services shall set the matter down for a hearing.

(b) At least twenty (20) days prior to the date set for the hearing, the board shall notify in writing the burial association or person holding a license of any charges made.

(c) The board shall afford the burial association or person an opportunity to be heard, at which hearing the association or person may be represented by counsel and shall be allowed oral testimony, affidavits, or depositions in reference thereto.

(d)(1) The board shall have power to subpoena and bring before it any person in this state or take the testimony by deposition of any person with the same fees and mileage and in the same manner as prescribed by law in judicial procedure in courts of this state in civil cases. The fees and mileage shall be paid by the party at whose request the witness is subpoenaed.

(2) The board shall also have the power to order the production of any books, records, and documents at the hearing.

(e)(1) If the board determines that the burial association or person is guilty of a violation of any provisions of this chapter, its or his or her

certificate of authority, charter, license, or other authority shall be revoked.

(2) However, if the burial association or person gives notice of appeal from any adverse decision of the board as set forth in § 23-78-125, then the burial association or person may, at the discretion of the board, continue to operate during the pendency of the appeal.

(3) If the board chooses not to permit the association or person to operate during the pendency of the appeal, then the board shall appoint a person to conduct the business of the association or person until the appeal has been heard.

History. Acts 1953, No. 91, § 17; 1981, No. 360, § 4; A.S.A. 1947, § 66-1817; Acts 2017, No. 788, § 89.

Amendments. The 2017 amendment, in (a), substituted "a certificate" for "any certificate", deleted "the provisions of" preceding "this chapter", substituted "before" for "prior to", and substituted "State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "Burial Association Board".

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-125. Revocation of certificate, license, charter, etc. — Appeal.

(a) Upon the revocation of a certificate of authority, charter, or other authority by the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services under any of the provisions of this chapter, the association or person whose certificate of authority, charter, license, or other authority has been revoked may appeal from the action of the board revoking the certificate of authority, charter, or other authority to the circuit court of the county in which the burial association may be located.

(b) Appeals shall be made in accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

History. Acts 1953, No. 91, § 21; 1981, No. 360, § 5; A.S.A. 1947, § 66-1821; Acts 2011, No. 875, § 5; 2017, No. 788, § 90.

Amendments. The 2017 amendment, in (a), substituted "a certificate" for "any certificate", "State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "Burial Association Board", and "may appeal" for "shall have the right of appeal".

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-78-126. Plan for excess financial resources — Approval required.

(a) A burial association that has excess financial resources, as determined by the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services, may request that the board approve a plan to pay death benefits in excess of the face value of certificates of benefits issued by the burial association to members of the burial association.

(b) On the approval of the board, the burial association shall submit a plan to the board to pay death benefits in excess of the face value of

certificates of benefits issued by the burial association to members of the burial association.

(c)(1) The plan described in subsection (b) of this section shall:

(A) Be based on the class of business of the burial association; and

(B) Require that death benefits are paid on a fair, proportionate, and equitable basis to members of the burial association.

(2) The plan shall not impugn the financial integrity of the burial association.

(d) In determining whether or not a burial association has excess financial resources, the board shall not consider the assets of a burial association that are attributable to certificates written after July 20, 1987, to be commingled with assets attributable to certificates written before July 20, 1987.

History. Acts 2015, No. 1030, § 2; 2017, No. 788, § 91.

Amendments. The 2017 amendment substituted "State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services" for "Burial Association Board" in (a).

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

CHAPTER 79

INSURANCE POLICIES GENERALLY

SUBCHAPTER.

RESEARCH REFERENCES

ALR. Comment Note — Validity, Construction, and Application of Premium Finance Agreements and Acts Governing Premium Finance Companies, 24 A.L.R.7th Art. 2 (2018).

Subchapter 1 — General Provisions

Effective Dates. Acts 2017, No. 500, § 3: Mar. 15, 2017. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that a Current Procedural Terminology code for digital mammography is available; that an update to Arkansas law is necessary to address the new Current Procedural Terminology code for digital mammography; and that this act is immediately necessary because of the need to maintain coverage and provide proper reimbursement for digital mammography. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

23-79-101. Definitions.

As used in this chapter:

(1) "Excepted benefits" means benefits under one (1) or more, or any combination thereof, of the following:

(A) Benefits not subject to requirements, including without limitation:

(i) Coverage only for accident or disability income insurance, or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance; and

(vii) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(B) Limited-scope dental or vision benefits;

(C) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(D) Coverage only for a specified disease or illness;

(E) Hospital indemnity or other fixed indemnity insurance; and

(F) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act, 42 U.S.C. § 1395ss(g)(1), coverage supplemental to the coverage provided under 10 U.S.C. § 1071 et seq., and similar supplemental coverage;

(2) "Policy" means the written contract of or written agreement for or effecting insurance, by whatever name called, and includes all clauses, riders, endorsements, and papers made a part thereof; and

(3)(A) "Premium" is the consideration for insurance, by whatever name called.

(B) Any assessment, or any membership, policy, survey, inspection, service, or similar fee or charge in consideration for a policy is deemed part of the premium.

History. Acts 1959, No. 148, §§ 269, 270; A.S.A. 1947, §§ 66-3202, 66-3203; Acts 2001, No. 1604, § 78; 2007, No. 496, § 15; 2019, No. 521, § 22.

Amendments. The 2019 amendment substituted "chapter" for "section and §§ 23-79-102 — 23-79-128, 23-79-131 — 23-79-134, and 23-79-202 — 23-79-210" in the introductory language; added (1) and redesignated the remaining subdivisions accordingly; and added the (3)(A) and (3)(B) designations.

23-79-102. Scope.

Sections 23-79-101, 23-79-103 — 23-79-107, 23-79-109 — 23-79-128, 23-79-131 — 23-79-134, 23-79-162, and 23-79-202 — 23-79-210 do not apply to:

(1) Reinsurance;

(2)(A) Policies or contracts not issued for delivery in this state nor delivered in this state, except:

(i) On subjects of insurance other than life or accident and health insurance, located or to be performed in this state; and

(ii) Pursuant to § 23-79-109(e).

(B) Subdivision (2)(A) of this section does not apply to group insurance certificates issued under group insurance policies carried out and delivered outside this state but covering a person that is a resident in this state;

(3) Wet marine and foreign trade insurance; and

(4) Title insurance, except that the following apply to this line:

(A) Section 23-79-101(2), §§ 23-79-109 — 23-79-111, 23-79-113, 23-79-116, 23-79-118, 23-79-119, and 23-79-202 — 23-79-205; and

(B) Section 23-79-121, provided that the insurer may authorize or require its title agents to provide the policy to the insured.

History. Acts 1959, No. 148, § 268; 1979, No. 691, § 1; A.S.A. 1947, § 66-3201; Acts 2001, No. 1604, § 79; 2007, No. 684, § 5; 2013, No. 355, § 12; 2015, No. 231, § 5; 2019, No. 689, § 2.

Amendments. The 2015 amendment redesignated part of (4) as (4)(A) and added (B).

The 2019 amendment inserted "23-79-162" in the introductory language.

23-79-107. Application — Statements as representations.

CASE NOTES

Misrepresentations, Omissions, Etc.

In a case decided under a former version of this section, in which an insurer rescinded a 2010 life insurance policy based on a misrepresentation that was unrelated to the cause of the insured's death, the beneficiary's bad-faith claim failed as a matter of law based on the company's good-faith defense, which was formerly part of this section but was deleted in 2011; the unjust enrichment claim also failed. The causal relationship requirement in subsection (c) was not a required element of the former good-faith defense. Gann v. Household Life Ins. Co., No. 3:13-cv-71-DPM, 2015 U.S. Dist. LEXIS 179306 (E.D. Ark. Mar. 20, 2015), aff'd, 668 Fed. Appx. 176 (8th Cir. 2016) (decision under prior law).

23-79-109. Filing and approval of forms — Definitions.

(a)(1)(A)(i) No basic insurance policy, or annuity contract form, or application form when written application is required and is to be made a part of the policy or contract, or printed rider or endorsement form or form of renewal certificate, shall be issued, delivered, or used as to a subject of insurance resident, located, or to be performed in this state unless the form has been filed with and approved by the Insurance Commissioner and, in the case of individual accident and health contracts, the rates have been filed with and approved by the commissioner.

(ii)*(a)* The commissioner may consider a nonprofit insurer's surplus levels in determining whether a proposed rate is excessive.

(b) Subdivision (a)(1)(A)(ii)*(a)* of this section does not apply to a nonprofit insurer that offers only limited scope dental benefits.

(B) This subsection shall not apply to:

(i) Policy or coverage forms for large commercial risks, as defined in subsection (g) of this section;

(ii) Commercial umbrella policy or coverage forms;

(iii) Excess umbrella policy or coverage forms;

(iv) Excess of loss policy or coverage forms;

(v) Public officials' liability policy or coverage forms;

(vi) Fiduciary liability policy or coverage forms;

(vii) Directors' and officers' liability policy or coverage forms;

(viii) Kidnap and ransom policy or coverage forms;

(ix) Political risk policy or coverage forms;

(x) Expropriation coverage policy or coverage forms;

(xi) Mortgage pool insurance policy or coverage forms;

(xii) Railroad protective liability policy or coverage forms;

(xiii) Equity loan programs, second mortgage coverage, policy or coverage forms;

(xiv) Highly protected risk forms;

(xv) Surety bonds;

(xvi) Policies, orders, endorsements, or forms of unique character designed for, and used with relation to, insurance upon a particular subject, or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life and accident and health insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder; or

(xvii) Policies, contracts, riders, endorsements, and certificates issued by surplus lines insurers.

(C) The exemption of a particular type of insurance policy form from the requirement that it be filed with the commissioner and expressly approved thereby is not to be taken by an insurer as meaning that any insurance effected by the use of such a form may in any fashion be inconsistent with the statutory and common law of this state that is properly applicable thereto.

(2) As to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed with and approved by the commissioner.

(3) No group accident and health certificate of insurance may be extended to residents of this state under a group accident and health policy issued outside this state that does not include the provisions required for group policies issued in this state unless the commissioner determines that the provisions are not appropriate for the coverage provided. Upon request of the commissioner, copies of the group accident and health policies issued outside this state shall be made available on an informational basis.

(4) On and after January 1, 1990, all Medicare supplement rates shall be based on a composite age basis only and shall not be based on any age banding or other groupings.

(5) Nothing in this subsection shall prohibit an insurer or hospital and medical service corporation issuing Medicare supplement insurance policies from using its usual and customary underwriting procedures or excluding preexisting health conditions. However, no insurer shall refuse to issue a Medicare supplement policy based solely on the age of the applicant.

(b)(1) Every filing shall be made not less than thirty (30) days in advance of any delivery. At the expiration of the thirty (30) days, the form or rate so filed shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by the commissioner.

(2) Approval of the form or rate by the commissioner shall constitute a waiver of any unexpired portion of the waiting period.

(3) The commissioner may extend by not more than an additional thirty (30) days the period within which he or she may so affirmatively approve or disapprove the form or rate by giving notice of the extension before expiration of the initial thirty-day period.

(4) At the expiration of the period as so extended, and in the absence of prior affirmative approval or disapproval, the form or rate shall be deemed approved.

(5) The commissioner may at any time, after notice and for cause shown, withdraw approval.

(c) Notification disapproving the form or withdrawing a previous approval shall state the grounds therefor.

(d) By order, the commissioner may exempt from the requirements of this section, for so long as he or she deems proper, any insurance document or form or type thereof as specified in the order to which, in his or her opinion, this section may not practically be applied or the filing and approval of which are, in his or her opinion, not desirable or necessary for the protection of the public.

(e) This section shall apply also to any form used by domestic insurers for delivery in a jurisdiction outside this state, if the insurance supervisory official of the jurisdiction informs the commissioner that the form is not subject to approval or disapproval by that official, and upon the commissioner's written notice requiring the form to be submitted to him or her for the purpose. The same standards that are applicable to forms for domestic use shall apply to such forms.

(f) No policy or contract form providing coverage for personal automobile liability that provides for a policy term of less than six (6) months shall be approved by the commissioner or issued for delivery in this state and used by insurers on and after January 1, 1992. However, the provisions of this subsection shall not restrict premium payment options offered by insurers.

(g)(1) For purposes of this section, "large commercial risk" means an insured that has:

(A) A total premium of two hundred fifty thousand dollars ($250,000) or more for property and casualty insurance;

(B) At least twenty-five (25) full-time employees; and

(C) A full-time certified risk manager to procure property and casualty insurance. For purposes of this subsection, "certified risk manager" means a risk manager with one (1) or more of the following credentials:

(i) Associate in risk management;

(ii) Chartered property casualty underwriter; or

(iii) Certified risk manager.

(2) The exemption for large commercial risk policy or coverage forms set forth in subdivision (a)(1) of this section shall not apply to workers' compensation, or employers' liability or professional liability insurance, including, but not limited to, medical malpractice insurance.

(3)(A) In procuring coverage, a large commercial risk shall certify that it:

(i) Meets the eligible criteria for an exempt commercial policyholder set out in this subsection;

(ii) Is aware that the policy is unregulated for rates and forms; and

(iii) Has the necessary expertise to negotiate its own policy language.

(B) This certification shall be completed annually and remain on file with the producing agent or broker.

(h) If the commissioner deems that the review as to either rates or forms, or both, required by this section as to any particular line or lines of insurance, can be performed in some other manner that provides sufficient protection to the consumers of this state and results in greater efficiency in bringing new or modified products within the line to market, the approval required by this section may be waived for such period as is deemed appropriate, or until revoked.

(i)(1) If the commissioner disapproves a rate, the insurer may request that the commissioner provide the insurer with an actuarial analysis, interpretation of statistical data, and other methodology that was reviewed by the commissioner or his or her staff.

(2) The information required under subdivision (i)(1) of this section shall be provided within five (5) working days after the receipt of the request.

History. Acts 1959, No. 148, § 276; 1975, No. 841, § 1; 1979, No. 691, § 2; 1981, No. 809, § 13; 1985, No. 804, § 1; A.S.A. 1947, § 66-3209; Acts 1987, No. 268, § 1; 1989, No. 710, § 2; 1989, No. 815, § 1; 1991, No. 1123, § 11; 1992 (1st Ex. Sess.), No. 72, § 1; 1993, No. 901, § 39; 1999, No. 458, §§ 3, 4; 2001, No. 1604, §§ 84-87; 2009, No. 726, § 37; 2013, No. 1187, § 1; 2013, No. 1339, § 1; 2015, No. 1164, § 4.

Amendments. The 2015 amendment deleted "the filing" preceding "an actuarial" in (i)(1).

CASE NOTES

Arkansas Deceptive Trade Practices Act.

Trial court properly ruled that an air ambulance service's claims under the Arkansas Deceptive Trade Practices Act against a plan insurer were precluded by the act's safe-harbor provision in § 4-88-101(3) because the service's claims were based on the terms and rates of the insurer's plans that were approved by the Insurance Commissioner under subdivision (a)(1)(A)(i) of this section. Air Evac EMS, Inc. v. USAble Mut. Ins. Co., 931 F.3d 647 (8th Cir. 2019).

23-79-110. Forms and premium rates — Grounds for disapproval — Definitions.

(a) The Insurance Commissioner shall disapprove a form filed under § 23-79-109, or withdraw a previous approval, only if the form:

(1) Violates or does not comply with state law;

(2) Contains or incorporates by reference, when the incorporation is otherwise permissible, an inconsistent, ambiguous, or misleading clause, or an exception and a condition that deceptively affect the risk purported to be assumed in the general coverage of the contract;

(3) Has a title, heading, or other indication of its provisions that is misleading; or

(4) Is printed or otherwise reproduced in such a manner that makes a provision of the form substantially illegible or not easily legible to persons of normal vision.

(b)(1) The commissioner shall disapprove a premium rate filed with an individual accident and health contract if the commissioner finds that the rate is not actuarially sound, is excessive, is inadequate, or is unfairly discriminatory.

(2) A rate is actuarially sound if it is:

(A) Supported by an actuarial analysis made by a member of the American Academy of Actuaries; and

(B) Based on generally accepted actuarial principles and methodologies that show the rate to be reasonable.

(3) An insurer's submission of an actuarially sound rate shall not foreclose the commissioner from relying upon a contrary opinion made by a member of the American Academy of Actuaries who utilized generally accepted actuarial principles and methodologies to contest the rate filed by the insurer.

(4) A rate is excessive if it is likely to produce a profit that is unreasonably high in relation to past and prospective loss experience for the form which the filing affects or if expenses are unreasonably high in relation to services given.

(5) A rate is not unfairly discriminatory if:

(A) It shows equitably the differences in expected losses and expenses; or

(B) Different premiums result for policyholders with like loss exposures but different expense factors or with like expense factors but different loss exposures, if the rates show the differences with reasonable accuracy.

(6) A rate is inadequate if the investment income attributable to the rate fails to satisfy projected losses and expenses for the form which the filing affects.

(c)(1) A rate on a particular policy form is approved when filed with the commissioner if the insurer has filed a loss ratio guarantee with the commissioner and complied with the terms of the loss ratio guarantee.

(2) A benefit is reasonable in relation to the premium so long as the insurer complies with the terms of the loss ratio guarantee.

(3)(A) The loss ratio guarantee shall be in writing, signed by an officer of the insurer, and contain at least the following:

(i) A recitation of the anticipated target loss ratio standards contained in the original actuarial memorandum filed with the policy form when it was originally approved;

(ii) A guarantee that if the new rate takes effect, the loss ratios in this state for the experience period in which the new rate takes effect and for each experience period thereafter until a new rate is filed shall meet or exceed the loss ratio standards referred to in subdivision (c)(3)(A)(i) of this section; and

(iii) A statement or guarantee that affected policyholders in this state shall be issued a proportional refund based on premium earned of the amount necessary to bring the total loss ratio up to the loss ratio standards referred to in subdivision (c)(3)(A)(i) of this section.

(B) If nationwide loss ratios are used, then the total amount refunded in this state shall equal the dollar amount necessary to

achieve the loss ratio standards multiplied by the total premium earned in this state on the policy form and divided by the total premium earned in a state on the policy form.

(C) The refund shall be made to a policyholder in this state who is insured under the applicable policy form on the last day of the experience period and whose refund would equal ten dollars ($10.00) or more.

(D) The refund shall include interest from the end of the experience period until the date of payment.

(E) The payment of the refund shall be made during the third quarter of the year following the experience period for which a refund is determined to be due.

(F) Refunds of less than ten dollars ($10.00) shall be aggregated by the insurer and paid to the State Insurance Department.

(4)(A) If the annual earned premium volume in this state under a policy form is less than one million dollars ($1,000,000) and therefore not actuarially credible, the loss ratio guarantee shall be based on the nationwide loss ratio for the policy form.

(B) If the total earned premium in this state is less than one million dollars ($1,000,000), the experience period shall be extended until the end of the calendar year in which one million dollars ($1,000,000) of earned premium is attained.

(5)(A) An insurer shall submit a guarantee that the loss ratio in this state or nationally, if applicable, for the year at issue shall be independently audited at the insurer's expense.

(B) An audit shall be made in the second quarter of the year following the end of the experience period and the audited results reported to the commissioner at or before the date for filing the policy experience exhibit.

(6) As used in this section:

(A)(i) "Experience period" means the period for a given rate filing for which a loss ratio guarantee is made beginning on the first day of the calendar year during which the rate first takes effect and ending on the last day of the calendar year during which the insurer earns one million dollars ($1,000,000) in premium on the form in this state or if the annual premium earned on the form in Arkansas is less than one million dollars ($1,000,000) nationally.

(ii) Successive experience periods shall be determined beginning on the first day following the end of the preceding experience period; and

(B) "Loss ratio" means the ratio of incurred claims to earned premium by number of years of policy duration for the combined durations.

(7)(A) An insurer whose rates on a policy form are approved according to a loss ratio guarantee shall provide a notice to an affected policyholder that advises that rates may be increased more than one (1) time a year.

(B) The notice shall be delivered to a new policyholder with policies subject to the loss ratio guarantee at or before the time of delivery of the policy.

(d) This section does not require an insurer to provide the notice required by this section on more than one (1) occasion to a policyholder while the policyholder is insured under the guaranteed form.

History. Acts 1959, No. 148, § 277; 1975, No. 841, § 2; 1985, No. 530, § 1; A.S.A. 1947, § 66-3210; Acts 1991, No. 398, § 1; 2001, No. 1604, §§ 88, 89; 2013, No. 1187, § 2; 2015, No. 231, § 6; 2015, No. 1164, § 5; 2015, No. 1210, § 3.

Amendments. The 2015 amendment by No. 231 substituted "or" for "and" following "misleading" in (a)(3).

The 2015 amendment by No. 1164 redesignated the former introductory language of (c)(3) as the introductory language of (c)(3)(A) and redesignated former (c)(3)(A)-(C) as (c)(3)(A)(i)-(iii); redesignated former (c)(3)(D)-(H) as (c)(3)(B)-(F); deleted "in subdivision (c)(6)(C) of this section" following "refund" in (c)(3)(D); and deleted former (c)(6), and redesignated the remaining subdivisions accordingly.

The 2015 amendment by No. 1210, in (a)(1), substituted "Violates" for "Is in violation of" and "state law" for "this code".

23-79-118. Noncomplying forms.

An insurance policy, rider, or endorsement issued and otherwise valid that contains any condition or provision not in compliance with state law is not rendered invalid but shall be construed and applied according to the conditions and provisions that would have applied had the policy, rider, or endorsement been in full compliance with state law.

History. Acts 1959, No. 148, § 284; A.S.A. 1947, § 66-3217; Acts 2015, No. 1210, § 4.

Amendments. The 2015 amendment substituted the first occurrence of "state law" for "the requirements of this code" and substituted "state law" for "this code" at the end of the section; and made stylistic changes.

23-79-119. Construction of policies.

(a) Every insurance contract shall be construed according to the entirety of its terms and conditions as set forth in the policy and as amplified, extended, or modified by any rider, endorsement, or application made a part of the policy.

(b) All insurance contracts that are issued for specific terms and that may be renewed for subsequent terms at the option of the insured or the insurer shall be construed from and after their respective dates of renewal as being new contracts to the extent of having incorporated therein all applicable public policy that by statute or rule may have become applicable to those contracts in the interval between:

(1) Original issuance or last renewal; and

(2) The renewal following the newly applicable statement of public policy.

(c)(1) Except as provided in this section, a health insurance issuer that provides individual health insurance coverage for major medical

benefits to an individual shall renew or continue in force that coverage at the option of the individual.

(2) General Exceptions. A health insurance issuer may nonrenew or discontinue health insurance coverage providing major medical benefits for an individual in the individual market based on only one (1) or more of the following:

(A) Nonpayment of the Premium. The individual has failed to pay premiums or contributions under the terms of the health insurance coverage or the issuer has not received timely premium payments;

(B) Fraud. The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(C) Termination of the Plan. The issuer is ceasing to offer major medical coverage in the individual market under applicable state or federal law;

(D) Movement Outside the Service Area. In the case of a health insurance issuer that offers health insurance for major medical coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area or in an area for which the issuer is authorized to do business, but only if the individual major medical coverage is terminated under this subdivision (c)(2)(D) uniformly without regard to any health status-related factor of covered individuals; and

(E) Association Membership Ceases. In the case of health insurance for major medical coverage that is made available in the individual market only through one (1) or more bona fide associations, the membership of the individual in the association, as the basis on which the coverage is provided, ceases but only if the major medical coverage is terminated under this subdivision (c)(2)(E) uniformly without regard to any health status-related factor of covered individuals.

(3) Requirements for Uniform Termination of Coverage — Particular Type of Coverage Not Offered. In the case in which an insurer decides to discontinue offering a particular type of health insurance providing major medical coverage offered to the individual market, coverage of this type may be discontinued by the issuer only if:

(A) The issuer provides to each covered individual with coverage of this type in the market notice of the discontinuation at least ninety (90) days before the date of the discontinuation of the coverage;

(B) The issuer offers to each individual in the individual market with coverage of this type the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in the market; and

(C) In exercising the option to discontinue coverage of this type and in offering the option of coverage under subdivision (c)(3)(B) of this section, the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.

(4) Discontinuance of Such Coverage — In General. Subject to this section, in any case in which a health insurance issuer elects to discontinue offering all health insurance providing major medical coverage in the individual market in this state, health insurance coverage may be discontinued by the issuer only if the issuer provides to the Insurance Commissioner and to each individual notice of the discontinuance at least one hundred eighty (180) days before the date of expiration of the coverage.

(5) Prohibition on Market Reentry. In the case of a discontinuation in the individual market under this section, the issuer may not provide for the issuance of any health insurance providing major medical coverage in the market and state involved during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(6) Exception for Uniform Modification of Coverage. At the time of coverage renewal, a health insurance issuer may modify the health insurance providing major medical coverage for a policy form offered to individuals in the individual market so long as the modification is consistent with state law and effective on a uniform basis among all individuals with that policy form.

(7) Application to Coverage Offered Only Through Associations. In applying this section in the case of health insurance providing major medical coverage that is made available by a health insurance issuer in the individual market through only one (1) or more associations, a reference to an "individual" includes a reference to such an association of which the individual is a member.

(8) For purposes of this section, the terms or phrases "health insurance issuer", "health insurance coverage" or "coverage", "Insurance Commissioner", "network plan", "health status-related factor", "bona fide association", "individual market", and "eligible individual" shall have the same meaning as defined in § 23-86-303.

(d) The commissioner may promulgate rules that are necessary to implement and enforce this section for the protection of policyholders.

History. Acts 1959, No. 148, § 285; 1981, No. 520, § 1; A.S.A. 1947, § 66-3218; Acts 1993, No. 901, § 40; 1999, No. 881, § 13; 2011, No. 886, § 1; 2019, No. 315, § 2706.

Amendments. The 2019 amendment substituted "rule" for "regulation" in the introductory language of (b).

23-79-120. Binders.

(a) Binders or other contracts for temporary insurance may be made orally or in writing and shall be deemed to include all the usual terms of the policy as to which the binder was given together with such applicable endorsements as are designated in the binder, except as superseded by the clear and express terms of the binder.

(b) No binder shall be valid beyond the issuance of the policy with respect to which it was given, or beyond ninety (90) days from its effective date, whichever period is the shorter.

(c) If the policy has not been issued, a binder may be extended or renewed beyond the ninety (90) days with the written approval of the Insurance Commissioner or in accordance with such rules relative thereto as the commissioner may promulgate.

(d) This section shall not apply to life insurance or accident and health insurance.

History. Acts 1959, No. 148, § 286; A.S.A. 1947, § 66-3219; Acts 2001, No. 1604, § 95; 2019, No. 315, § 2707.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (c).

23-79-123. Renewal by certificate.

(a)(1) Any insurance policy terminating by its terms at a specified expiration date and not otherwise renewable may be renewed or extended at the option of the insurer upon a currently authorized policy form and at the premium rate then required for that type of policy, for a specific additional period or periods by certificate or by endorsement of the policy or by electronic certificate or electronic endorsement properly executed and without requiring the issuance of a new policy.

(2) The insurer shall retain the electronic transmittal and a copy of the certificate or endorsement as a part of the insurer's records.

(b) By reasonable rules or by order the Insurance Commissioner may deny the use of such certificates for renewal of such types of policies or in such circumstances as may be necessary or advisable to protect insureds who may otherwise hold forms of policies which no longer contain all of the benefits or conditions applicable under similar policies currently issued by the same insurer.

(c) The provisions of this section shall not apply to policies issued for large commercial risks.

History. Acts 1959, No. 148, § 289; A.S.A. 1947, § 66-3222; Acts 1999, No. 458, § 7; 2005, No. 506, § 40; 2019, No. 315, § 2708.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (b).

23-79-139. Benefits for alcohol or drug dependency treatment — Definition.

(a)(1) Every insurer, hospital and medical service corporation, and health maintenance organization transacting accident and health insurance in this state shall offer and make available under all group policies, contracts, and plans providing hospital and medical coverage on an expense incurred, service, or prepaid basis benefits for the necessary care and treatment of alcohol and other drug dependency that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles, and coinsurance factors, except as provided in this section.

(2)(A) The offer for these benefits shall be subject to the right of the policy or contract holder to reject the coverage or select any alternative level of benefits.

(B) The rejection by the policy or contract holder shall be in writing.

(b) Any benefits provided under alcohol or drug dependency coverage shall be determined as necessary care and treatment in an alcohol or drug dependency treatment facility or care and treatment in a hospital.

(c) Treatment may include detoxification, administration of a therapeutic regimen for the treatment of alcohol or drug dependent or substance abusing persons, and related services.

(d) The facility or unit may be:

(1) A unit within a general hospital or an attached or freestanding unit of a general hospital;

(2) A unit within a psychiatric hospital or an attached or freestanding unit of a psychiatric hospital; or

(3) A freestanding facility specializing in treatment of persons who are substance abusers or are alcohol or drug dependent, and may be identified as "chemical dependency, substance abuse, alcoholism, or drug abuse facilities", "social setting detoxification facilities", and "medical detoxification facilities", or by other names if the purpose is to provide treatment of alcohol or drug dependent or substance abusing persons, but shall not include halfway houses or recovery farms.

(e) Every policy or contract of insurance that provides benefits for alcohol or drug dependency treatment and that provides total annual benefits for all illnesses in excess of six thousand dollars ($6,000) is subject to the following conditions:

(1) The policy or contract shall provide, for each twenty-four-month period, a minimum benefit of six thousand dollars ($6,000) for the necessary care and treatment of alcohol or drug dependency;

(2) No more than one-half (½) of the policy's or contract's maximum benefits for alcohol or drug dependency for a twenty-four-month period shall be paid for the necessary care and treatment of alcohol or drug dependency in any thirty-consecutive-day period; and

(3) The policy or contract shall provide a minimum benefit of twelve thousand dollars ($12,000) for the necessary care and treatment of alcohol or drug dependency for the life of the recipient of benefits.

(f) For the purposes of this section, the term "alcohol or drug dependency treatment facility" means a public or private facility or unit in a facility that provides treatment twenty-four (24) hours a day for alcohol or drug dependency or substance abuse, that provides a program for the treatment of alcohol or other drug dependency under a written treatment plan approved and monitored by a physician, and that is also properly licensed or accredited to provide those services by the Division of Aging, Adult, and Behavioral Health Services of the Department of Human Services.

(g) Nothing in this section shall prohibit any certificate or contract from requiring the most cost-effective treatment setting to be utilized by the person undergoing necessary care and treatment for alcohol or drug dependency.

(h) As used in this section, "alcohol or drug dependency" means the pathological use or abuse of alcohol or other drugs in a manner or to a

degree that produces an impairment in personal, social, or occupational functioning and that may, but need not, include a pattern of tolerance and withdrawal.

(i) This section shall apply to group policies or contracts delivered or issued for delivery or renewed in this state after November 17, 1987, but shall not apply to blanket short-term travel accident only, limited or specified disease, conversion policies or contracts, nor to policies or contracts referred to as Medicare supplement policies, designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act.

History. Acts 1987, No. 1047, §§ 1-6; 2001, No. 1604, § 103; 2013, No. 1107, § 43; 2017, No. 913, § 118.

Amendments. The 2017 amendment, in (f), substituted "provides treatment" for "is engaged in providing treatment", "dependency under" for "dependency pursuant to", and "Division of Aging, Adult, and Behavioral Health Services" for "Division of Behavioral Health Services", and made stylistic changes.

23-79-140. Mammograms — Breast ultrasounds — Definitions.

(a) As used in this section:

(1) "Breast ultrasound" means an imaging technique that uses harmless, high-frequency sound waves to produce detailed images of the breast in order to screen for and diagnose breast disease, such as cancer;

(2) "Diagnostic mammography" means a problem-solving radiologic procedure of higher intensity than screening mammography provided to women who are suspected to have breast pathology, usually characterized by the following medical events:

(A) Patients are usually referred for analysis of palpable abnormalities or for further evaluation of mammographically detected abnormalities;

(B) All images are reviewed by the physician interpreting the study, and additional views are obtained as needed; and

(C) A physical examination of the breast by the interpreting physician to correlate the radiologic findings is performed as part of the study when indicated;

(3) "Mammography" means radiography of the breast; and

(4)(A) "Screening mammography", including digital breast tomosynthesis, means a radiologic procedure provided to a woman, who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer.

(B) The procedure entails at least two (2) views of each breast and includes a physician's interpretation of the results of the procedure.

(b)(1) Every accident and health insurance company, hospital service corporation, health maintenance organization, or other accident and health insurance provider in the State of Arkansas shall offer as an essential health benefit, coverage for screening mammography and breast ultrasound for the diagnosis of breast disease such as cancer and the evaluation of dense breast tissue:

(A) A baseline mammogram for an insured woman who is thirty-five to forty (35-40) years of age;

(B) An annual mammogram for an insured woman who is forty (40) years of age or older;

(C) Upon recommendation of a woman's physician, without regard to age, when the woman has had a prior history of breast cancer, when the woman's mother or sister has had a history of breast cancer, positive genetic testing, or other risk factors; and

(D) A comprehensive ultrasound screening of an entire breast or breasts if a mammogram screening demonstrates heterogeneously dense or extremely dense breast tissue and the woman's primary healthcare provider or radiologist determines a comprehensive ultrasound screening is medically necessary.

(2) Insurance coverage for screening mammograms, including digital breast tomosynthesis, and breast ultrasounds shall not prejudice coverage for diagnostic mammograms or breast ultrasounds, as recommended by the woman's physician.

(3) A fully insured large group insurer that issues, renews, or extends a health benefit plan in this state shall also provide coverage for an optional screening mammography and breast ultrasound benefit as described under subdivision (b)(1) of this section.

(4) As used in this subsection, an accident and health insurance company, hospital service corporation, health maintenance organization, or other accident and health insurance provider does not include benefits under one (1) or more, or any combination thereof, of the following:

(A) Coverage only for accident or disability income insurance, or any combination thereof;

(B) Coverage issued as a supplement to liability insurance;

(C) Liability insurance, including general liability insurance and automobile liability insurance;

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Limited-scope dental or vision benefits;

(H) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(I) Coverage only for a specified disease or illness;

(J) Hospital indemnity or other fixed indemnity insurance; or

(K) Other similar insurance coverage, specified in rules, under which benefits for medical care are secondary or incidental to other insurance benefits.

(c) [Repealed.]

(d) Furthermore, no insurer shall pay for mammographies performed in an unaccredited facility after January 1, 1990.

(e)(1) After January 1, 2014, an accident and health insurance company, hospital service corporation, health maintenance organization, or other accident and health insurance provider shall use the

Healthcare Common Procedure Coding System G code for digital mammography services or the Current Procedural Terminology code as established for digital mammography and listed in the most recent annual edition of Current Procedural Terminology published by the American Medical Association.

(2) The codes used for digital mammography services described in subdivision (e)(1) of this section shall be reimbursed at a minimum of one and five-tenths (1.5) times the Medicare reimbursement rate.

(f)(1) Benefits under this section are subject to any policy provisions that apply to other services covered by the policy, except that an insurance policy shall not impose a copayment or deductible for a screening mammogram.

(2) A breast ultrasound may be subject to any applicable copayment as required under a health benefit plan but shall not be subject to a deductible.

History. Acts 1989, No. 292, §§ 2-4, 6; 1995, No. 508, § 2; 2001, No. 1604, § 104; 2013, No. 1259, § 2; 2017, No. 500, § 2; 2017, No. 708, §§ 1-5; 2019, No. 477, § 1.

A.C.R.C. Notes. Acts 2017, No. 500, § 1, provided: "Legislative findings. The General Assembly finds that:

"(1) Health insurance payments to healthcare providers are primarily driven by Current Procedural Terminology (CPT) codes that are listed in the annual edition of Current Procedural Terminology published by the American Medical Association;

"(2) If a Current Procedural Terminology code is not available for a healthcare procedure or is not listed in the most recent annual edition of Current Procedural Terminology, temporary Healthcare Common Procedure Coding System (HCPCS) G codes are used;

"(3) In the struggle against breast cancer, digital mammography provides a powerful proven tool for early detection of disease, facilitating early intervention and increasing the chances for a complete recovery for patients; and

"(4) There is limited access to digital mammography service particularly in rural areas of the state because of the significant increase in the cost of equipment and time and the lack of adjustment of payment."

Amendments. The 2017 amendment by No. 500 rewrote (e).

The 2017 amendment by No. 708 added "Breast ultrasounds — Definitions" to the section heading; rewrote (a) and (b); repealed (c); and added (f).

The 2019 amendment redesignated (b) as (b)(1); in the introductory language of (b)(1), deleted "after January 1, 1990" following "State of Arkansas shall offer" and substituted "dense breast tissue" for "dense breast including"; redesignated former (b)(1) through (b)(5) as (b)(1)(A) through (b)(1)(D), and (b)(2); substituted "an insured woman" for "a woman covered by such a policy" in (b)(2)(A); substituted "An annual mammogram for an insured woman who is forty (40) years of age or older" for "A mammogram for a woman covered by such a policy who is forty (40) years of age or older, every year" in (b)(2)(B); added (b)(3) and (b)(4); and made a stylistic change.

23-79-147. Prescription medication — Definitions.

(a) As used in this section:

(1) "Commissioner" means the Insurance Commissioner of the State Insurance Department;

(2) "Insurance policy" means any individual, group, or blanket policy, contract, or evidence of coverage written, issued, amended, delivered, or renewed in this state, or which provides such insurance for residents of

this state by an insurance company, hospital medical corporation, or health maintenance organization;

(3) "Medical literature" means articles from major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 107 Stat. 591 (1993), 42 U.S.C. § 1395x(t)(2)(B), as amended; and

(4) "Metastatic cancer" means cancer that has spread from a primary or original site of the cancer to surrounding or nearby tissues, lymph nodes, or other parts of the body.

(b) An insurance policy that provides coverage for prescription drugs shall not limit or exclude coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed if:

(1) The drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one (1) or more of these standard reference compendia:

(A)(i) The American Hospital Formulary Service Drug Information;

(ii) The National Comprehensive Cancer Network Drugs and Biologics Compendium;

(iii) The Elsevier Gold Standard's Clinical Pharmacology; or

(B) The drug has been recognized as safe and effective for treatment of that specific type of cancer in two (2) articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature; or

(2) Other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services or the commissioner may be used to provide coverage by an insurer at the insurer's discretion.

(c) Coverage of a drug required by subsection (b) of this section includes medically necessary services associated with the administration of the drug, provided that such services are covered by the insurance policy.

(d) Except as provided in subsection (e) of this section, subsection (b) of this section shall not be construed to do any of the following:

(1) Require coverage for any drug if the United States Food and Drug Administration has determined its use to be contraindicated for the treatment of the specific type of cancer for which the drug has been prescribed;

(2) Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the United States Food and Drug Administration; or

(3) Create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

(e) An insurance policy that provides coverage for the treatment of metastatic cancer shall not limit or exclude coverage under the health benefit plan for a drug approved by the United States Food and Drug Administration that is on the prescription drug formulary of the insurance policy by mandating that a covered person with metastatic cancer undergo step therapy unless the preferred drug is consistent with best practices that:

(1) Are used for the treatment of metastatic cancer or associated conditions under:

(A) The United States Food and Drug Administration-approved indication; or

(B) The National Comprehensive Cancer Network Drugs and Biologics Compendium indication; or

(2) Use evidence-based, peer-reviewed, recognized medical literature.

History. Acts 1995, No. 1231, §§ 1, 2; 1999, No. 466, § 1; 2009, No. 270, § 1; 2019, No. 699, §§ 1-3.

Amendments. The 2019 amendment added (a)(4) and (e); added "Except as provided in subsection (e) of this section" in the introductory language of (d); and inserted "United States" in (d)(1) and (d)(2).

23-79-150. Healthcare plan — Health carrier — Definitions.

(a)(1)(A) "Healthcare plan" means any individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by a carrier in this state, including indemnity and managed care plans.

(B) "Healthcare plan" does not mean a plan that provides coverage only for:

(i) A specified accident or accident-only coverage or long-term care insurance as defined in the Long-Term Care Insurance Act, § 23-97-201 et seq. [repealed];

(ii) A Medicare supplement policy of insurance, as defined by the Insurance Commissioner by rule;

(iii) Coverage under a plan through Medicare, Medicaid, or the Federal Employees Health Benefit Program;

(iv) Any coverage issued under United States Code Title 10, Chapter 55, existing on January 1, 2001, and any coverage issued as supplemental to that coverage; and

(v) Any coverage issued as supplemental to liability insurance, workers' compensation, or similar insurance.

(2) "Health carrier" means any accident and health insurance company, referred to in law as disability insurance company, hospital or medical services corporation, or health maintenance organization, including a so-called dental maintenance organization, issuing or delivering healthcare plans in this state.

(b)(1) Every health carrier shall offer optional coverage in its healthcare plans for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder. Treatment shall include both surgical and nonsurgical procedures.

(2) This coverage shall be provided for medically necessary diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology.

(3) This coverage shall be the same as that provided for any other musculoskeletal disorder in the body and shall be provided whether prescribed or administered by a physician or dentist.

(c)(1) The policyholder shall accept or reject the optional coverage in writing on the application.

(2) The application shall specifically and conspicuously inform the policyholder that rejection of the option means that covered benefits provided to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder.

(d) Nothing in this section shall prevent an insurer from including such coverage for any or all musculoskeletal disorders affecting any bone or joint in the face, neck, or head as part of a policy's basic coverage, in lieu of offering optional coverage.

(e) This section shall apply to those healthcare plans issued, delivered, renewed, extended, amended, or modified on or after August 13, 2001.

History. Acts 2001, No. 1470, §§ 1, 2; 2019, No. 315, § 2709.

Amendments. The 2019 amendment substituted "rule" for "regulation" in (a)(1)(B)(ii).

23-79-152. Cancellation, increase in premium, and negative risk rating prohibited when insured not at fault.

(a) Except as provided in subsection (c) of this section, when a person is innocent of any negligent or intentional act that was the proximate cause of an accident or injury whether or not a claim is filed under any policy or contract of insurance, no insurer authorized to transact the business of motor vehicle liability insurance in this state shall solely as a result of the accident or injury:

(1) Cancel the person's insurance policy or contract;

(2) Increase the premium during the term or upon renewal of the person's insurance policy or contract; or

(3) Lower or otherwise negatively impact the risk rating of the person.

(b) Any insurer that violates the provisions of this section shall be subject to the procedure and penalties provided under the Trade Practices Act, § 23-66-201 et seq.

(c) Nothing in this section shall prevent an insurer from canceling, not renewing, or revising the rating of an insurance policy if the insurer is otherwise permitted to do so by statute or rule.

History. Acts 2005, No. 1194, § 1; 2019, No. 315, § 2710.

Amendments. The 2019 amendment substituted "rule" for "regulation" in (c).

23-79-155. Commercial general liability insurance.

CASE NOTES

Retroactive Operation.

In an action arising from the subcontractors' faulty work on a home, the district court properly dismissed the general contractor's breach of contract claim against the insurer because defective work resulting in damages only to the work product itself was not an "occurrence" as defined in the commercial general liability policy under Essex. The court of appeals could not retroactively apply this section, which overruled Essex; instead, the insurance policy was governed by the law in effect at the time of its issuance. J-McDaniel Constr. Co. v. Mid-Continent Cas. Co., 761 F.3d 916 (8th Cir. 2014).

23-79-160. Health insurance information regarding Health Care Independence Program.

Upon notification to enrollees in the Health Care Independence Program established by the Health Care Independence Act of 2013, § 20-77-2401 et seq. [repealed], that the Health Care Independence Program ends on December 31, 2016, the Department of Human Services shall simultaneously provide to enrollees in the Health Care Independence Program the following information in accordance with the Arkansas Health Reform Act of 2015, Acts 2015, No. 46:

(1) Upon program termination, recommend an alternative healthcare coverage model and legislative framework to ensure the continued availability of healthcare services for vulnerable populations covered by the Health Care Independence Program;

(2) Explore and recommend options to modernize Medicaid programs serving the indigent, aged, and disabled; and

(3) Identify the populations eligible for and participating in the Health Care Independence Program, including:

(A) Individuals newly eligible for health coverage under the Health Care Independence Program; and

(B) Individuals previously eligible for Medicaid before the effective date of the Health Care Independence Program, whether under a Medicaid waiver or some other eligibility criteria.

History. Acts 2015, No. 1278, § 1.

Publisher's Notes. The Arkansas Health Reform Act of 2015, Acts 2015, No. 46, referred to in this section, is noted at Title 20, Chapter 77, Subchapter 24.

23-79-161. Payment for oral anticancer medications — Definitions.

(a) As used in this section:

(1) "Anticancer medication" means any drug or biologic that is used to kill, slow, or prevent the growth of cancerous cells;

(2)(A) "Health benefit plan" means any group or blanket plan, policy, or contract for healthcare services issued, renewed, or extended in this state and outside this state for an enrollee or certificate holder who is a resident of this state by healthcare insurers, including indemnity and managed care plans and the plans providing health benefits to state and public school employees under § 21-5-401 et seq., but excluding individual major medical plans and plans providing healthcare services under Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., and the Public Employee Workers' Compensation Act, § 21-5-601 et seq.

(B) "Health benefit plan" does not include an accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policy; and

(3) "Healthcare insurer" means any insurance company, hospital and medical service corporation, or health maintenance organization issuing or delivering health benefit plans in this state and that is subject to any of the following laws:

(A) The insurance laws of this state;

(B) Section 23-75-101 et seq., pertaining to hospital and medical service corporations; and

(C) Section 23-76-101 et seq., pertaining to health maintenance organizations.

(b) Every health benefit plan that is issued, renewed, or extended in this state and every group health benefit plan that is issued, renewed, or extended outside this state, for an enrollee or certificate holder who is a resident of this state that provide coverage for anticancer medications that are injected or intravenously administered by a healthcare provider or a patient shall not require a higher copayment, coinsurance, or deductible amount for orally administered anticancer medications than the health benefit plan requires for injected or intravenously administered anticancer medications regardless of the formulation or benefit category determination by the health benefit plan.

(c)(1) A healthcare insurer shall not impose a copayment, coinsurance, or a deductible amount or a combination of a copayment, coinsurance, or a deductible amount charged to the insured for orally administered anticancer medications that is greater than the copayment, coinsurance, or deductible amount charged to the insured for injected or intravenously administered anticancer medications.

(2) A healthcare insurer shall not reclassify benefits with respect to cancer treatment medications or increase a copayment, deductible, or coinsurance amount for covered cancer treatment medications that are injected or intravenously administered unless:

(A) The increase is applied generally to other medical or pharmaceutical benefits covered under the plan and is not done to circumvent subdivision (c)(1) of this section;

(B) The reclassification of benefits with respect to cancer treatment medications is done in a manner that is consistent with this section; or

(C) A healthcare insurer is applying cost-sharing increases consistent with the annual increases in the cost of health care.

(d)(1) A health benefit plan may adopt policies to ensure that claims for coverage of orally administered anticancer medications submitted for payment comply with the same coding, documentation, and other requirements necessary for payment as those claims for coverage of injected or intravenously administered anticancer medications.

(2) The Insurance Commissioner shall promulgate rules as may be necessary to implement this section.

History. Acts 2017, No. 543, § 1.
Effective Dates. Acts 2017, No. 543, § 1: Jan. 1, 2018.

23-79-162. Notice of renewal in affiliate or subsidiary.

(a) This section applies to all forms of property and casualty insurance written under this subchapter.

(b) A notice of nonrenewal is not required if:

(1) The insured is transferred from an insurer to an affiliate insurer for future coverage; and

(2) The transfer results in substantially similar or broader coverage to the insured.

(c)(1) Notice of a renewal in an affiliate or subsidiary shall be provided to a policyholder according to the renewal notice requirements applicable to the type or kind of policy being renewed.

(2) The notice of renewal in an affiliate or subsidiary described in subdivision (c)(1) of this section shall state:

(A) The reason for the change to the affiliate or subsidiary;

(B) That coverage shall be provided by the affiliate or subsidiary unless the policyholder chooses to pursue coverage with an insurer outside the group of affiliated insurers; and

(C) The relevant information about changes to the policy's deductible, provisions, and amount of premium.

(d) At least ninety (90) days in advance of mailing the notice of renewal in an affiliate or subsidiary to its policyholders, an insurer shall notify the Insurance Commissioner of its intention to renew policies in bulk in an affiliate or subsidiary and provide the commissioner with a copy of the notice to policyholders.

(e) This section does not repeal or supersede any requirements of the Insurance Holding Company Regulatory Act, § 23-63-501 et seq., including without limitation the provisions of § 23-63-515 that are applicable to material transactions between an insurer and an insurer's affiliates.

History. Acts 2019, No. 689, § 3.

23-79-163. Excepted benefits.

Excepted benefits are not subject to the requirements of this subchapter regarding coverage of a specific person, provider, treatment, service, condition, or disease unless that coverage is required by law.

History. Acts 2019, No. 521, § 23.

Subchapter 2 — Suits Against Insurers

SECTION.

23-79-202. Limitation of actions.

CASE NOTES

Choice of Law.

Insured's claim against insurers was not time-barred, because under Arkansas Supreme Court precedent, Arkansas law applied and therefore a policy provision requiring suit to be filed before the statute of limitations expired was void under this section. Simmons Foods, Inc. v. Indus. Risk Insurers, 863 F.3d 792 (8th Cir. 2017).

23-79-204. Venue.

(a) An action brought in this state by or in behalf of the insured or beneficiary against an insurer as to a loss occurring or benefits or rights provided under an insurance policy or annuity contract shall be brought in either:

(1) The county in which the loss occurred, or the insured died, in the case of life insurance; or

(2) The county of the insured's residence at the time of the loss or death.

(b) Actions brought in this state against an insurer under § 23-79-210, which provides that the liability insurer may be sued directly where the insured is legally immune, shall be brought either in the county where the injury or damage occurred or where one (1) or more of the plaintiffs resided at the time of the injury or damage.

(c) The venue of all other actions against a domestic insurer shall be as provided in § 16-60-101.

History. Acts 1959, No. 148, § 301; A.S.A. 1947, § 66-3234; Acts 2015, No. 830, § 3.

Amendments. The 2015 amendment substituted "§ 16-60-101" for "§ 16-60-104" in (c).

23-79-208. Damages and attorney's fees on loss claims.

CASE NOTES

Analysis

Applicability.
Defense or Justification.
Penalty and Attorney's Fees.

Applicability.

Recovery of attorney's fees to insureds in an insurance-contract action is exclusively available under this section, and an award under § 16-22-308 is prohibited; because § 16-22-308 does not contain a condition on a fee award, this section falls squarely within § 16-22-308's exception that it does not apply when attorney's fees are "otherwise provided by law." Gafford v. Allstate Ins. Co., 2015 Ark. 110, 459 S.W.3d 277 (2015).

Defense or Justification.

Insured was not entitled to a statutory penalty and attorney's fees based on an insurer's delay in paying the insured's mortgage; it was clear that the delay was initially caused by the mortgage company's failure to furnish proper and necessary information and later by the insured's refusal to consent to the company's use of the funds paid by the insurer to pay the mortgage. Jackson v. Allstate Ins. Co., 785 F.3d 1193 (8th Cir. 2015).

Penalty and Attorney's Fees.

Insured was not entitled to relief against an insurer under this section or § 23-79-209 because (1) the insured did not allege the insurer breached a contractual duty, and (2) the insured's suit did not arise from a declaratory judgment action or the insurer's effort to cancel or lapse a policy, so the insured suffered no "loss" covered by either statute. Cooper v. Gen. Am. Life Ins. Co., 827 F.3d 729 (8th Cir. 2016).

Insured's claim for statutory 12% penalty damages and attorney's fees against insurers was properly denied because the insured did not recover at least 80% of the amount the insured sought. Simmons Foods, Inc. v. Indus. Risk Insurers, 863 F.3d 792 (8th Cir. 2017).

Cited: Farm Bureau Mut. Ins. Co. of Ark. v. VJM Enters., LLC, 2017 Ark. App. 28, 511 S.W.3d 349 (2017).

23-79-209. Allowance of attorney's fees in suits to terminate, modify, or reinstate policy.

RESEARCH REFERENCES

Ark. L. Rev. Mark James Chaney, Recent Developments: Interpreting Arkansas Law, The Eighth Circuit Holds an Award of Attorneys' Fees Shall Be Provided to a Policy Holder Who Partially Prevails Against an Insurer's Action Denying Its Duty to Defend the Holder, 66 Ark. L. Rev. 1145 (2013).

CASE NOTES

Applicability.

Insured was not entitled to relief against an insurer under § 23-79-208 or this section because (1) the insured did not allege the insurer breached a contractual duty, and (2) the insured's suit did not arise from a declaratory judgment action or the insurer's effort to cancel or lapse a policy, so the insured suffered no "loss" covered by either statute. Cooper v. Gen. Am. Life Ins. Co., 827 F.3d 729 (8th Cir. 2016).

Subchapter 3 — Minimum Standards — Commercial Property and Casualty Insurance Policies

23-79-307. Standards — Definition.

(a) In addition to other applicable provisions of the Arkansas Insurance Code, insurers and insurance policies subject to the provisions of this subchapter shall meet the following standards:

(1) Notice of claim given by or on behalf of the named insured to any authorized agent of the insurer with specific information to identify the insured is deemed notice of claim to the insurer;

(2) Policies may be issued for a term in excess of twelve (12) months with the premium adjustable on an annual basis if the policy contains an express provision to that effect. At least thirty (30) days' advance notice in writing of the premium to be charged on the policy anniversary date must be given to the insured and the agent of record if the insured has furnished the information necessary to calculate the premium;

(3) Forms or endorsements that reduce, restrict, or modify the original policy coverage shall be accepted and signed by the named insured if those forms or endorsements were issued:

(A) After the policy inception date but before renewal of the policy; and

(B) Not at the request of the named insured;

(4) Any policy providing an aggregate limit of liability within the schedule of limits must include a notice specifying that the policy limit is an "aggregate". The aggregate limit provision must be clearly defined within the policy;

(5)(A) Policies containing provisions that would reduce the limit of liability available for judgments or settlements by the amount of payment made for defense cost or claim expenses shall not be approved by the Insurance Commissioner unless a separate limit for defense costs equal to one hundred percent (100%) of the annual aggregate limit of liability stated in the policy for judgments or settlements is offered for defense costs or claims expenses to the insured. However, no policy covering automobile liability insurance may contain the defense within the limits concept.

(B) This subsection does not apply to policies or contracts that the commissioner may exempt by order upon a finding that this subsection may not practically be applied or that its application is not necessary or desirable for the protection of the public;

(6)(A) When an insurer revises its rates or rules and the revision results in a premium increase equal to or greater than twenty-five percent (25%) on any renewal policy issued for a term of twelve (12)

months or less, the insurer shall mail or deliver to the insured's agent not less than thirty (30) days prior to the effective date of renewal, and to the insured not less than ten (10) days prior to the effective date of renewal, notice specifically stating the insurer's intention to increase the premium by an amount equal to or greater than twenty-five percent (25%).

(B) If the notice is not given as stated in subdivision (a)(6)(A) of this section, the insurer is required to extend the existing policy thirty (30) days from the date the notice is mailed or delivered. The premium for the policy as extended in such circumstances shall be no more than the pro rata premium of the existing policy;

(7) Except in the case of nonpayment of premium, an insurer shall renew a policy unless a written notice of nonrenewal is mailed at least sixty (60) days prior to the expiration date of the policy or, for a policy for a term longer than one (1) year and not having a fixed expiration date, sixty (60) days prior to the anniversary date; and

(8) Policies containing an exclusion for punitive damages must include a definition of punitive damages substantially similar to the following: "Punitive damages" are damages that may be imposed to punish a wrongdoer and to deter others from similar conduct.

(b) As used in this section, "renewal" or "renew" means the issuance and delivery by an insurer of a policy superseding a policy previously issued by the insurer at the end of the previously issued policy period if the policy is delivered by:

(1) The same insurer; or

(2) An affiliate or subsidiary, as those terms are defined in § 23-63-503, that has a financial strength rating that is:

(A) Issued by an industry-recognized independent insurance rating company; and

(B) At least as good as the insurer issuing the superseded policy.

(c) This section does not repeal or supersede any requirements of the Insurance Holding Company Regulatory Act, § 23-63-501 et seq., including without limitation the provisions of § 23-63-515 that are applicable to material transactions between an insurer and an insurer's affiliates.

History. Acts 1987, No. 204, § 3; 1989, No. 797, § 1; 1991, No. 1123, §§ 14, 15; 1999, No. 458, § 9; 2001, No. 1555, §§ 13-15; 2019, No. 343, § 1; 2019, No. 689, § 1.

Amendments. The 2019 amendment by No. 343 rewrote (a)(3) and added (a)(3)(A) and (a)(3)(B).

The 2019 amendment by No. 689 added the (a) designation; and added (b) and (c).

23-79-310. Rules.

The Insurance Commissioner may promulgate such reasonable rules as are necessary to carry out the provisions of this subchapter.

History. Acts 1987, No. 204, § 8; 2019, No. 315, § 2711.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in the section heading and the text.

23-79-311. Motor vehicle liability insurance — Extraterritorial provision.

(a)(1) Motor vehicle liability insurance applies to the amounts that the owner is legally obligated to pay as damages because of accidental bodily injury and accidental property damage arising out of the ownership or operation of a motor vehicle if the accident occurs in the United States, its possessions, or Canada.

(2) Motor vehicle liability insurance must afford limits of liability not less than those required under the financial responsibility laws of the jurisdiction of this state.

(b) If the accident occurs outside this state but in the United States, its possessions, or Canada and if the limits of liability of the financial responsibility or compulsory insurance laws of the applicable jurisdiction exceed the limits of liability of the financial responsibility laws of this state, the motor vehicle liability insurance is deemed to comply with the limits of liability of the laws of the applicable jurisdiction.

(c) For purposes of this section, "motor vehicle" is defined as provided in § 27-14-104.

History. Acts 2001, No. 309, § 1; 2019, No. 391, § 9.

Amendments. The 2019 amendment substituted "§ 27-14-104" for "§ 27-14-207" in (c).

Subchapter 4 — Medicare Supplement Insurance Minimum Standards Act

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A.C.R.C. Notes. Acts 2017, No. 684, § 1, provided: "Legislative findings and intent.

"(a) The General Assembly finds that:

"(1) Arkansans who are under sixty-five (65) years of age and have Medicare due to a disability are unable to purchase certain policies of Medigap coverage, also known as Medicare supplement insurance, under State Insurance Department Rule 27; and

"(2) The exclusion of the Medigap coverage option under State Insurance Department Rule 27 may create an undue financial burden on Arkansas residents.

"(b) It is the intent of the General Assembly to ensure that Arkansans have access to Medigap coverage that is currently available to individuals with disabilities residing in other states.

"(c)(1) The State Insurance Department shall amend State Insurance Department Rule 27 to allow for the sale and purchase of certain policies of Medigap coverage by Arkansans who are under sixty-five (65) years of age and have Medi-

care due to a disability.

"(2) On or before January 1, 2018, the department shall submit its proposed amendment of the rule under subdivision (c)(1) of this section to the Senate Committee on Insurance and Commerce for review and approval.

"(3) The department shall include with its proposed amendment of the rule under subdivision (c)(1) of this section:

"(A) Written findings that address the Medigap premium assessment process; and

"(B) A written description of specific efforts the department has taken to ensure that Medigap premiums that are made available under the proposed rule are competitively priced."

23-79-404. Standards for policy provisions and authority to promulgate rules.

(a) No Medicare supplement policy or certificate in force in this state shall contain benefits that duplicate benefits provided by Medicare.

(b) Notwithstanding any other provision of law of this state, a Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(c) The Insurance Commissioner shall adopt reasonable rules to establish specific standards for policy provisions of Medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with applicable laws of this state, including §§ 23-66-306, 23-79-109, and 23-79-112. No requirement of the Arkansas Insurance Code relating to minimum required policy benefits, other than the minimum standards contained in this subchapter, shall apply to Medicare supplement policies and certificates. The standards may cover, but not be limited to:

(1) Terms of renewability;
(2) Initial and subsequent conditions of eligibility;
(3) Nonduplication of coverage;
(4) Probationary periods;
(5) Benefit limitations, exceptions, and reductions;
(6) Elimination periods;
(7) Requirements for replacement;
(8) Recurrent conditions; and
(9) Definitions of terms.

(d) The commissioner shall adopt reasonable rules to establish minimum standards for benefits, claims payment, marketing practices and compensation arrangements, and reporting practices for Medicare supplement policies and certificates.

(e) The commissioner may adopt, from time to time, such reasonable rules as are necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations promulgated thereunder, including, but not limited to:

(1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements;

(2) Establishing a uniform methodology for calculating and reporting loss ratios;

(3) Assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance;

(4) Establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases;

(5) Establishing a policy for holding public hearings prior to approval of premium increases; and

(6) Establishing standards for Medicare SELECT policies and certificates.

(f) The commissioner may adopt reasonable rules that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement policy or certificate.

History. Acts 1992 (1st Ex. Sess.), No. 72, § 3; 2019, No. 315, § 2712.

Amendments. The 2019 amendment substituted "rules" for "regulations" in the section heading, in the introductory language of (c) and (e), and in (d) and (f).

23-79-405. Loss ratio standards.

Medicare supplement policies shall return to policyholders benefits which are reasonable in relation to the premiums charged. The Insurance Commissioner shall issue reasonable rules to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred healthcare expenses when coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

History. Acts 1992 (1st Ex. Sess.), No. 72, § 3; 2019, No. 315, § 2713.

Amendments. The 2019 amendment substituted "rules" for "regulations".

23-79-406. Disclosure standards — Definition.

(a) In order to provide for full and fair disclosure in the sale of Medicare supplement policies, no Medicare supplement policy or certificate shall be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.

(b) The Insurance Commissioner shall prescribe the format and content of the outline of coverage required by subsection (a) of this section. For purposes of this section, "format" means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type, and arrangement of text and captions. The outline of coverage shall include:

(1) A description of the principal benefits and coverage provided in the Medicare supplement policy;

(2) A statement of the renewal provisions, including any reservation by the issuer of a right to change premiums, and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and

(3) A statement that the outline of coverage is a summary of the Medicare supplement policy issued or applied for and that the Medicare supplement policy should be consulted to determine governing contractual provisions.

(c)(1) The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for Medicare which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare.

(2) Except in the case of direct response insurance policies, the commissioner may require by rule that the informational brochure be provided to any prospective insureds eligible for Medicare concurrently with delivery of the outline of coverage.

(3) With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

(d) The commissioner may adopt rules for captions or notice requirements determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages for all accident and health insurance policies sold to persons eligible for Medicare by reason of age, other than:

(1) Medicare supplement policies;

(2) Disability income policies;

(3) Basic, catastrophic, or major medical expense policies; or

(4) Single premium, nonrenewable policies.

(e) The commissioner may adopt reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and health policies, subscriber contracts, or certificates by persons eligible for Medicare.

History. Acts 1992 (1st Ex. Sess.), No. 72, § 3; 2001, No. 1603, §§ 35, 36; 2019, No. 315, § 2714.

Amendments. The 2019 amendment substituted "rules" for "regulations" in the introductory language of (d) and in (e).

23-79-409. Administrative procedures.

Rules adopted pursuant to this subchapter shall be subject to the provisions of § 23-61-108 and to the provisions of the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

History. Acts 1992 (1st Ex. Sess.), No. 72, § 3; 2019, No. 315, § 2715.

Amendments. The 2019 amendment substituted "Rules" for "Regulations".

23-79-410. Penalties.

In addition to any other applicable penalties for violations of the Arkansas Insurance Code, the Insurance Commissioner may require issuers violating any provisions of this subchapter or rules promulgated pursuant to this subchapter to cease marketing any Medicare supplement policy or certificate in this state which is related directly or indirectly to a violation or may require the issuer to take such actions as are necessary to comply with the provisions of this subchapter, or both.

History. Acts 1992 (1st Ex. Sess.), No. 72, § 3; 2019, No. 315, § 2716.

Amendments. The 2019 amendment substituted "rules" for "regulations".

Subchapter 6 — Coverage for Diabetes Treatment

SECTION.
23-79-604. Exclusions.
23-79-605. Rules.

23-79-604. Exclusions.

This subchapter shall not be construed as prohibiting a health insurance policy from excluding from coverage diabetes self-management training or equipment or supplies and related services for the treatment of Type I diabetes, Type II diabetes, or gestational diabetes when the training, equipment, supplies, and services are not medically necessary, provided that the medical necessity determination is made in accordance with generally accepted standards of the medical profession and other applicable laws and rules.

History. Acts 1997, No. 1249, § 4; 2019, No. 315, § 2717.

Amendments. The 2019 amendment substituted "rules" for "regulations".

23-79-605. Rules.

The State Insurance Department shall develop and promulgate rules to implement the provisions of this subchapter.

History. Acts 1997, No. 1249, § 5; 2019, No. 315, § 2718.

Amendments. The 2019 amendment substituted "rules" for "regulations" in the section heading and the text.

Subchapter 7 — Tax Credits for Medically Necessary Foods

SECTION.
23-79-703. Health insurance coverage for medically necessary foods — Definition.

23-79-703. Health insurance coverage for medically necessary foods — Definition.

(a) As used in this section, "medical disorder requiring specialized nutrients or formulas" means the following inherited metabolic disorders involving a failure to properly metabolize certain nutrients:

(1) Nitrogen metabolism disorder;
(2) Phenylketonuria;
(3) Maple syrup urine disease;
(4) Homocystinuria;
(5) Citrullinemia;
(6) Argininosuccinic acidemia;
(7) Tyrosinemia, type 1;
(8) Very-long-chain acyl-CoA dehydrogenase deficiency;
(9) Long-chain 3-hydroxyacyl-CoA dehydrogenase deficiency;
(10) Trifunctional protein deficiency;
(11) Glutaric acidemia, type 1;
(12) 3-methylcrotonyl CoA carboxylase deficiency;
(13) Propionic acidemia;
(14) Methylmalonic acidemia due to mutase deficiency;
(15) Methlmalonic acidemia due to cobalamin A,B defect;
(16) Isovaleric acidemia;
(17) Ornithine transcarbamylase deficiency;
(18) Non-ketotic hyperglycinemia;
(19) Glycogen storage diseases;
(20) Disorders of creatine metabolism;
(21) Malonic aciduria;
(22) Carnitine palmitoyl transferase deficiency type II;
(23) Glutaric aciduria type II; and
(24) Sulfite oxidase deficiency.

(b)(1) A health plan issued, delivered, amended, or modified in this state after January 1, 2018, shall provide the minimum benefits under subsection (c) of this section for medical foods, including without limitation:

(A) Low-protein modified food products;
(B) Amino-acid-based elemental formulas;
(C) Extensively hydrolyzed protein formulas;
(D) Formulas with modified vitamin or mineral content; and
(E) Modified nutrient content formulas.

(2)(A) The products and formulas listed in subdivision (b)(1) of this section shall be covered by a health plan regardless of delivery method, whether enteral or oral, or sole source or supplemental, or the age of the covered person, for the treatment of a covered person with a medical disorder requiring specialized nutrients or formulas if:

(i) Either of the following occurs:

(a) The medical food or low-protein modified food products, regardless of delivery method, are prescribed by a healthcare provider licensed under § 17-95-401 et seq. as medically necessary; or

(b) A healthcare provider licensed under § 17-95-401 et seq. issues a written order stating that a medical food is medically necessary for the therapeutic treatment of a medical disorder requiring specialized nutrients or formulas as described in subdivision (b)(1) of this section; and

(ii) The product or formula is administered under the direction of a licensed healthcare practitioner under § 17-95-401 et seq. and shall only be administered under the direction of a clinical geneticist and a registered dietitian.

(B) As used in subdivision (b)(2)(A) of this section, a "healthcare provider" does not include a nurse practitioner or physician's assistant.

(3) To be covered by a health plan, treatment of a medical disorder requiring specialized nutrients or formulas shall be:

(A) Derived from evidence-based practice guidelines; and

(B) Efficacious.

(c)(1) A health insurance policy, contract, certificate, or healthcare plan issued in this state by an insurance company, hospital medical service corporation, health maintenance organization, or a self-funded or self-insured governmental plan, whether an individual or group policy, contract, certificate, or healthcare plan, that covers the insured and the insured's family shall provide coverage and reimbursement for the treatment of a medical disorder requiring specialized nutrients or formulas in accordance with subsection (b) of this section.

(2) Benefits provided under the Arkansas Medicaid Program or coverage limited to expenses from an accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policy or plan is exempt from the requirement of subdivision (c)(1) of this section.

(3) The benefit provided under subdivision (c)(1) of this section may be subject to a deductible, copayments, coinsurance, or other patient cost-sharing amounts required by the health plan.

(d) If the cost of the products or formulas described in subdivision (b)(1) of this section for a covered person exceeds the income tax credit of two thousand four hundred dollars ($2,400) per year per covered person allowed under § 23-79-702 and the covered person cannot afford insurance coverage for treatment of a medical disorder requiring specialized nutrients or formulas as described in subdivision (b)(1) of this section, the Department of Health shall reimburse the healthcare provider up to one thousand dollars ($1,000) per covered person from any funds appropriated for the required healthcare service, including screening, diagnostic, and treatment services.

History. Acts 1999, No. 1113, § 3; 2001, No. 1603, § 38; 2001, No. 1654, § 1; 2003, No. 1440, § 2; 2017, No. 1096, § 1.

Amendments. The 2017 amendment added "Definition" in the section heading; and rewrote the section.

Subchapter 8 — Arkansas Health Insurance Consumer Choice Act

23-79-802. Definitions.

As used in this subchapter:

(1) "Health benefits plan" means any individual, blanket, or group plan, policy, or contract for healthcare services, issued or delivered by a healthcare insurer, health maintenance organization, or hospital and medical service corporation, excluding plans, policies, or contracts providing healthcare benefits or healthcare services pursuant to Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., the Public Employee Workers' Compensation Act, § 21-5-601 et seq., and the no-fault medical and hospital benefit requirements under § 23-89-202; and

(2)(A)(i) "State-mandated health benefits" means coverages for healthcare services or benefits required by state law or state rules, requiring the reimbursement or utilization related to a specific health illness, injury, or condition of the covered person or inclusion of a specific category of licensed healthcare practitioner to be provided to the covered person in a health benefits plan for a health-related condition of a covered person.

(ii) However, for the purposes of the options provided by this subchapter, state-mandated health benefits that may be excluded, in whole or in part, shall not include any healthcare services or benefits that were mandated by Acts 1971, No. 34.

(B) "State-mandated health benefits" does not mean standard provisions or rights required to be present in a health benefit plan pursuant to state law or rules unrelated to a specific health illness, injury, or condition of the insured, including, but not limited to, those related to continuation of benefits in § 23-86-114, or entitlement to a conversion policy under § 23-86-115.

History. Acts 2001, No. 924, § 2; 2019, No. 315, § 2719.

Amendments. The 2019 amendment substituted "rules" for "regulations" in (2)(A)(i).

23-79-803. Requirements relating to offering a health benefits plan not subject to state-mandated health benefits.

(a) Every group accident and health insurer, hospital and medical service corporation, or health maintenance organization transacting health or accident and health insurance in this state may offer, as an option, a group health benefits plan that, either in whole or in part, does not provide state-mandated health benefits on group health benefits plans under state law.

(b) Every accident and health insurer transacting individual major medical insurance in this state may offer, as an option, an individual health benefits plan that, either in whole or in part, does not provide state-mandated health benefits on individual health benefit plans under state law.

(c) In each sale of health policies or health contracts in which the proposed insured has selected a health benefits plan that, either in whole or in part, does not provide state-mandated health benefits, the accident and health insurer, hospital and medical service corporation, or health maintenance organization shall provide to the policyholder and to each certificate holder of a group health benefit plan a written notice, in a form and manner required by rule promulgated by the Insurance Commissioner, that one (1) or more of the mandated benefits are not included in the health benefit plan selected by the policyholder.

History. Acts 2001, No. 924, § 3; 2003, No. 1359, § 1; 2019, No. 315, § 2720.

Amendments. The 2019 amendment deleted "or regulation" following "rule" in (c).

23-79-805. Rules.

The Insurance Commissioner may promulgate rules necessary to implement the provisions of this subchapter.

History. Acts 2001, No. 924, § 5; 2019, No. 315, § 2721.

Amendments. The 2019 amendment substituted "rules" for "regulations" in the section heading and the text.

Subchapter 12 — Coverage for Colorectal Cancer Screening

SECTION.

Effective Dates. Acts 2019, No. 910, § 6346(b): July 1, 2019. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that this act revises the duties of certain state entities; that this act establishes new departments of the state; that these revisions impact the expenses and operations of state government; and that the sections of this act other than the two uncodified sections of this act preceding the emergency clause titled 'Funding and classification of cabinet-level department secretaries' and 'Transformation and Efficiencies Act transition team' should become effective at the beginning of the fiscal year to allow for implementation of the new provisions at the beginning of the fiscal year. Therefore, an emergency is declared to exist, and Sections 1 through 6343 of this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2019".

23-79-1201. Definitions.

As used in this subchapter:

(1) "Covered person" means a person who is and continues to remain eligible for coverage under a healthcare policy and is covered under a healthcare policy;

(2)(A) "Healthcare policy" means:

(i) An individual or group health insurance policy providing coverage on an expense-incurred basis;

(ii) An individual or group service or indemnity type contract issued by a nonprofit corporation;

(iii) An individual or group service contract issued by a health maintenance organization;

(iv) A group accident and sickness insurance policy issued by a fraternal benefit society, a nonprofit hospital service corporation, a nonprofit medical service corporation, a group healthcare plan, a health maintenance organization, or any similar entity; and

(v) A policy issued by or in connection with:

(a) The Arkansas medical assistance program and its contracted insurers, whether providing services on a managed-care or fee-for-service basis;

(b) The state employees' and public school teachers' health insurance programs;

(c) A self-insured group arrangement to the extent not preempted by federal law; and

(d) A managed healthcare delivery entity of any type or description.

(B) "Healthcare policy" does not include an accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policy; and

(3) "Persons at high risk for colorectal cancer" means:

(A) Individuals over fifty (50) years of age or who face a high risk for colorectal cancer because of:

(i) The presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy;

(ii) A family history of colorectal cancer in close relatives of parents, brothers, sisters, or children;

(iii) Genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis;

(iv) A personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or

(v) The presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and

(B) Any additional or expanded definition of "persons at high risk for colorectal cancer" as recognized by medical science and determined by the Secretary of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

History. Acts 2005, No. 2236, § 2; 2019, No. 910, § 5107.

Amendments. The 2019 amendment substituted "Secretary of the Department

of Health" for "Director of the Department of Health" in (3)(B).

23-79-1202. Coverage — Applicability.

(a) A healthcare policy subject to this subchapter executed, delivered, issued for delivery, continued, or renewed in this state on or after August 1, 2005, shall include colorectal cancer examinations and laboratory tests within the healthcare policy's coverage.

(b) The coverage shall include colorectal cancer examinations and laboratory tests for:

(1) Covered persons who are fifty (50) years of age or older;

(2) Covered persons who are less than fifty (50) years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and

(3) Covered persons experiencing the following symptoms of colorectal cancer as determined by a physician licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.:

(A) Bleeding from the rectum or blood in the stool; or

(B) A change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.

(c) After August 1, 2005, each employer that offers a healthcare policy to employees shall offer all eligible employees at the time of hiring or healthcare policy renewal a healthcare policy that includes colorectal cancer examinations and laboratory tests within the coverage of the employee's healthcare policy.

(d)(1) The colorectal screening shall involve an examination of the entire colon, including:

(A) The following examinations or laboratory tests, or both:

(i) An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;

(ii) A double-contrast barium enema every five (5) years; or

(iii) A colonoscopy every ten (10) years; and

(B) Any additional medically recognized screening tests for colorectal cancer required by the Secretary of the Department of Health, determined in consultation with appropriate healthcare organizations.

(2) The covered person shall determine the choice of screening strategies in consultation with a healthcare provider.

(3) Colorectal screening examinations shall be according to the choices and frequency provided by this subsection for all other covered persons.

(e) Screenings shall be limited to the following guidelines for the management or subsequent need for follow-up colonoscopy:

(1) If the initial colonoscopy is normal, follow-up is recommended in ten (10) years;

(ii) All adverse determinations for healthcare services, medications, or equipment prescribed by a physician are made by a physician who possesses a current and valid unrestricted license to practice medicine in Arkansas.

(B) Utilization review shall not require prior authorization of emergent telemedicine services.

(g)(1) A health benefit plan may adopt policies to ensure that healthcare services provided through telemedicine submitted for payment comply with the same coding, documentation, and other requirements necessary for payment as an in-person service other than the in-person requirement.

(2) If deemed necessary, the State Insurance Department may promulgate rules containing additional standards and procedures for the utilization of telemedicine to provide healthcare services through health benefit plans if the additional standards and procedures do not conflict with this subchapter or § 17-80-117 and are applied uniformly by all health benefit plans.

(h) A health benefit plan shall not prohibit a healthcare professional from charging a patient enrolled in a health benefit plan for healthcare services provided by audio-only communication that are not reimbursed under the health benefit plan.

History. Acts 2015, No. 887, § 4; 2017, No. 203, § 4.

Amendments. The 2017 amendment substituted "applies" for "shall apply" in (a)(1) and (a)(2); rewrote (b), (c)(1) and (c)(2); added (c)(3); added (d)(1); redesignated former (d)(1) through (d)(3) as (d)(2) through (d)(4); deleted former (d)(4)(A)(i); deleted the (d)(4)(A)(ii) designation; substituted "a health benefit plan" for "an insurer" in (d)(4)(B); inserted "for healthcare services, medications, or equipment prescribed by a physician" in (f)(2)(A)(ii); added (h); and made stylistic changes.

Subchapter 17 — Emerging Therapy Act of 2017

23-79-1701. Title.

This subchapter shall be known and may be cited as the "Emerging Therapy Act of 2017".

History. Acts 2017, No. 1089, § 2.

23-79-1702. Definitions.

As used in this subchapter:

(1) "Board" means the State and Public School Life and Health Insurance Board;

(2) "Choosing Wisely Initiative" means the initiative established by the American Board of Internal Medicine Foundation that seeks to advance a national dialogue on avoiding wasteful or unnecessary medical tests, treatments, and procedures;

(3) "Emerging therapies" means therapeutic services that have not historically been covered but for which new evidence may demonstrate therapeutic enhancements or opportunities for cost avoidance, or both;

(4) "Evidence" means peer-reviewed objective studies of emerging therapies; and

(5) "Regenerative injection therapy" means a nonsurgical orthopedic treatment performed by injecting into a joint or soft tissue a substance that stimulates the growth of normal cells and tissues for the purpose of strengthening or repairing a painful or injured joint or connective tissue.

History. Acts 2017, No. 1089, § 2.

23-79-1703. State and Public School Life and Health Insurance Board — Requirements.

(a) By the end of plan year 2017, the State and Public School Life and Health Insurance Board shall explore the evidence supporting opportunities for benefit modification informed by:

(1) The Choosing Wisely Initiative;

(2) Emerging therapies; and

(3) Therapeutic alternatives to invasive surgical procedures, such as regenerative injection therapy.

(b) By July 2018, the board shall:

(1) Identify and consider implementation of pilot programs that include stepped therapy or center of excellence approaches, or both, for which evidence demonstrates cost savings to the plan; and

(2) Identify opportunities to stimulate conversations between patients and providers about appropriate and necessary treatment, including treatment recommendations identified by the Choosing Wisely Initiative.

History. Acts 2017, No. 1089, § 2.

23-79-1704. Legislative findings.

The General Assembly finds that:

(1) The State and Public School Life and Health Insurance Board has a fiduciary obligation to explore cost-effective treatments for its members;

(2) There are emerging technologies that could serve as cost-effective alternatives to surgical procedures; and

(3) Clinical organizations are increasingly providing public guidance on quality treatment practices.

History. Acts 2019, No. 391, § 10.

(ii) All adverse determinations for healthcare services, medications, or equipment prescribed by a physician are made by a physician who possesses a current and valid unrestricted license to practice medicine in Arkansas.

(B) Utilization review shall not require prior authorization of emergent telemedicine services.

(g)(1) A health benefit plan may adopt policies to ensure that healthcare services provided through telemedicine submitted for payment comply with the same coding, documentation, and other requirements necessary for payment as an in-person service other than the in-person requirement.

(2) If deemed necessary, the State Insurance Department may promulgate rules containing additional standards and procedures for the utilization of telemedicine to provide healthcare services through health benefit plans if the additional standards and procedures do not conflict with this subchapter or § 17-80-117 and are applied uniformly by all health benefit plans.

(h) A health benefit plan shall not prohibit a healthcare professional from charging a patient enrolled in a health benefit plan for healthcare services provided by audio-only communication that are not reimbursed under the health benefit plan.

History. Acts 2015, No. 887, § 4; 2017, No. 203, § 4.

Amendments. The 2017 amendment substituted "applies" for "shall apply" in (a)(1) and (a)(2); rewrote (b), (c)(1) and (c)(2); added (c)(3); added (d)(1); redesignated former (d)(1) through (d)(3) as (d)(2) through (d)(4); deleted former (d)(4)(A)(i); deleted the (d)(4)(A)(ii) designation; substituted "a health benefit plan" for "an insurer" in (d)(4)(B); inserted "for healthcare services, medications, or equipment prescribed by a physician" in (f)(2)(A)(ii); added (h); and made stylistic changes.

Subchapter 17 — Emerging Therapy Act of 2017

23-79-1701. Title.

This subchapter shall be known and may be cited as the "Emerging Therapy Act of 2017".

History. Acts 2017, No. 1089, § 2.

23-79-1702. Definitions.

As used in this subchapter:

(1) "Board" means the State and Public School Life and Health Insurance Board;

(2) "Choosing Wisely Initiative" means the initiative established by the American Board of Internal Medicine Foundation that seeks to advance a national dialogue on avoiding wasteful or unnecessary medical tests, treatments, and procedures;

(3) "Emerging therapies" means therapeutic services that have not historically been covered but for which new evidence may demonstrate therapeutic enhancements or opportunities for cost avoidance, or both;

(4) "Evidence" means peer-reviewed objective studies of emerging therapies; and

(5) "Regenerative injection therapy" means a nonsurgical orthopedic treatment performed by injecting into a joint or soft tissue a substance that stimulates the growth of normal cells and tissues for the purpose of strengthening or repairing a painful or injured joint or connective tissue.

History. Acts 2017, No. 1089, § 2.

23-79-1703. State and Public School Life and Health Insurance Board — Requirements.

(a) By the end of plan year 2017, the State and Public School Life and Health Insurance Board shall explore the evidence supporting opportunities for benefit modification informed by:

(1) The Choosing Wisely Initiative;

(2) Emerging therapies; and

(3) Therapeutic alternatives to invasive surgical procedures, such as regenerative injection therapy.

(b) By July 2018, the board shall:

(1) Identify and consider implementation of pilot programs that include stepped therapy or center of excellence approaches, or both, for which evidence demonstrates cost savings to the plan; and

(2) Identify opportunities to stimulate conversations between patients and providers about appropriate and necessary treatment, including treatment recommendations identified by the Choosing Wisely Initiative.

History. Acts 2017, No. 1089, § 2.

23-79-1704. Legislative findings.

The General Assembly finds that:

(1) The State and Public School Life and Health Insurance Board has a fiduciary obligation to explore cost-effective treatments for its members;

(2) There are emerging technologies that could serve as cost-effective alternatives to surgical procedures; and

(3) Clinical organizations are increasingly providing public guidance on quality treatment practices.

History. Acts 2019, No. 391, § 10.

(4) "Originating site" means a site at which a patient is located at the time healthcare services are provided to him or her by means of telemedicine;

(5) "Remote patient monitoring" means the use of synchronous or asynchronous electronic information and communication technology to collect personal health information and medical data from a patient at an originating site that is transmitted to a healthcare professional at a distant site for use in the treatment and management of medical conditions that require frequent monitoring;

(6) "Store-and-forward technology" means the asynchronous transmission of a patient's medical information from a healthcare professional at an originating site to a healthcare professional at the distant site; and

(7)(A) "Telemedicine" means the use of electronic information and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient.

(B) "Telemedicine" includes store-and-forward technology and remote patient monitoring.

(C) For the purposes of this subchapter, "telemedicine" does not include the use of:

(i) Audio-only communication, including without limitation interactive audio;

(ii) A facsimile machine;

(iii) Text messaging; or

(iv) Electronic mail systems.

History. Acts 2015, No. 887, § 4; 2017, No. 203, § 4.

Amendments. The 2017 amendment inserted "and the Arkansas Works Program" in (2)(A)(ii); rewrote (4) and (5); added (6) and (7); and made a stylistic change.

23-79-1602. Coverage for telemedicine.

(a)(1) This subchapter applies to all health benefit plans delivered, issued for delivery, reissued, or extended in Arkansas on or after January 1, 2016, or at any time when any term of the health benefit plan is changed or any premium adjustment is made thereafter.

(2) Notwithstanding subdivision (a)(1) of this section, this subchapter applies to the Arkansas Medicaid Program on and after January 1, 2016.

(b) A healthcare professional providing a healthcare service provided through telemedicine shall comply with the requirements of the Telemedicine Act, § 17-80-401 et seq.

(c)(1) A health benefit plan shall provide coverage and reimbursement for healthcare services provided through telemedicine on the same basis as the health benefit plan provides coverage and reimbursement for health services provided in person, unless this subchapter specifically provides otherwise.

(2) A health benefit plan is not required to reimburse for a healthcare service provided through telemedicine that is not comparable to the same service provided in person.

(3) A health benefit plan may voluntarily reimburse for healthcare services provided through means described in § 23-79-1601(7)(C).

(d)(1) A health benefit plan shall provide a reasonable facility fee to an originating site operated by a healthcare professional or a licensed healthcare entity if the healthcare professional or licensed healthcare entity is authorized to bill the health benefit plan directly for healthcare services.

(2) The combined amount of reimbursement that a health benefit plan allows for the compensation to the distant site and the originating site shall not be less than the total amount allowed for healthcare services provided in person.

(3) Payment for healthcare services provided through telemedicine shall be provided to the distant site and the originating site upon submission of the appropriate procedure codes.

(4) This section does not:

(A) Prohibit a health benefit plan from paying a facility fee to a provider at the distant site in addition to a fee paid to the healthcare professional; or

(B) Require a health benefit plan to pay more for a healthcare service provided through telemedicine than would have been paid if the healthcare service was delivered in person.

(e) A health benefit plan shall not impose on coverage for healthcare services provided through telemedicine:

(1) An annual or lifetime dollar maximum on coverage for services provided through telemedicine other than an annual or lifetime dollar maximum that applies to the aggregate of all items and services covered;

(2) A deductible, copayment, coinsurance, benefit limitation, or maximum benefit that is not equally imposed upon all healthcare services covered under the health benefit plan; or

(3) A prior authorization requirement for services provided through telemedicine that exceeds the prior authorization requirement for in-person healthcare services under the health benefit plan.

(f) This subchapter does not prohibit a health benefit plan from:

(1) Limiting coverage of healthcare services provided through telemedicine to medically necessary services, subject to the same terms and conditions of the covered person's health benefit plan that apply to services provided in person; or

(2)(A) Undertaking utilization review, including prior authorization, to determine the appropriateness of healthcare services provided through telemedicine, provided that:

(i) The determination of appropriateness is made in the same manner as determinations are made for the treatment of any illness, condition, or disorder covered by the health benefit plan whether the service was provided in-person or through telemedicine; and

(ii) All adverse determinations for healthcare services, medications, or equipment prescribed by a physician are made by a physician who possesses a current and valid unrestricted license to practice medicine in Arkansas.

(B) Utilization review shall not require prior authorization of emergent telemedicine services.

(g)(1) A health benefit plan may adopt policies to ensure that healthcare services provided through telemedicine submitted for payment comply with the same coding, documentation, and other requirements necessary for payment as an in-person service other than the in-person requirement.

(2) If deemed necessary, the State Insurance Department may promulgate rules containing additional standards and procedures for the utilization of telemedicine to provide healthcare services through health benefit plans if the additional standards and procedures do not conflict with this subchapter or § 17-80-117 and are applied uniformly by all health benefit plans.

(h) A health benefit plan shall not prohibit a healthcare professional from charging a patient enrolled in a health benefit plan for healthcare services provided by audio-only communication that are not reimbursed under the health benefit plan.

History. Acts 2015, No. 887, § 4; 2017, No. 203, § 4.

Amendments. The 2017 amendment substituted "applies" for "shall apply" in (a)(1) and (a)(2); rewrote (b), (c)(1) and (c)(2); added (c)(3); added (d)(1); redesignated former (d)(1) through (d)(3) as (d)(2) through (d)(4); deleted former (d)(4)(A)(i); deleted the (d)(4)(A)(ii) designation; substituted "a health benefit plan" for "an insurer" in (d)(4)(B); inserted "for healthcare services, medications, or equipment prescribed by a physician" in (f)(2)(A)(ii); added (h); and made stylistic changes.

Subchapter 17 — Emerging Therapy Act of 2017

23-79-1701. Title.

This subchapter shall be known and may be cited as the "Emerging Therapy Act of 2017".

History. Acts 2017, No. 1089, § 2.

23-79-1702. Definitions.

As used in this subchapter:

(1) "Board" means the State and Public School Life and Health Insurance Board;

(2) "Choosing Wisely Initiative" means the initiative established by the American Board of Internal Medicine Foundation that seeks to advance a national dialogue on avoiding wasteful or unnecessary medical tests, treatments, and procedures;

(3) "Emerging therapies" means therapeutic services that have not historically been covered but for which new evidence may demonstrate therapeutic enhancements or opportunities for cost avoidance, or both;

(4) "Evidence" means peer-reviewed objective studies of emerging therapies; and

(5) "Regenerative injection therapy" means a nonsurgical orthopedic treatment performed by injecting into a joint or soft tissue a substance that stimulates the growth of normal cells and tissues for the purpose of strengthening or repairing a painful or injured joint or connective tissue.

History. Acts 2017, No. 1089, § 2.

23-79-1703. State and Public School Life and Health Insurance Board — Requirements.

(a) By the end of plan year 2017, the State and Public School Life and Health Insurance Board shall explore the evidence supporting opportunities for benefit modification informed by:

(1) The Choosing Wisely Initiative;

(2) Emerging therapies; and

(3) Therapeutic alternatives to invasive surgical procedures, such as regenerative injection therapy.

(b) By July 2018, the board shall:

(1) Identify and consider implementation of pilot programs that include stepped therapy or center of excellence approaches, or both, for which evidence demonstrates cost savings to the plan; and

(2) Identify opportunities to stimulate conversations between patients and providers about appropriate and necessary treatment, including treatment recommendations identified by the Choosing Wisely Initiative.

History. Acts 2017, No. 1089, § 2.

23-79-1704. Legislative findings.

The General Assembly finds that:

(1) The State and Public School Life and Health Insurance Board has a fiduciary obligation to explore cost-effective treatments for its members;

(2) There are emerging technologies that could serve as cost-effective alternatives to surgical procedures; and

(3) Clinical organizations are increasingly providing public guidance on quality treatment practices.

History. Acts 2019, No. 391, § 10.

Subchapter 18 — Coverage for Newborn Screening for Spinal Muscular Atrophy

SECTION.

23-79-1801. Definitions.

As used in this subchapter:

(1)(A) "Health benefit plan" means:

(i) An individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by an insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state; and

(ii) Any health benefit program receiving state or federal appropriations from the State of Arkansas, including the Arkansas Medicaid Program, the Health Care Independence Program [expired], commonly referred to as the "Private Option", and the Arkansas Works Program, or any successor program.

(B) "Health benefit plan" includes:

(i) An indemnity and managed care plan; and

(ii) A nonfederal governmental plan as defined in 29 U.S.C. § 1002(32), as it existed on January 1, 2019.

(C) "Health benefit plan" does not include:

(i) A disability income plan;

(ii) A credit insurance plan;

(iii) Insurance coverage issued as a supplement to liability insurance;

(iv) Medical payments under an automobile or homeowner's insurance plan;

(v) A health benefit plan provided under Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., or the Public Employee Workers' Compensation Act, § 21-5-601 et seq.;

(vi) A plan that provides only indemnity for hospital confinement;

(vii) An accident-only plan;

(viii) A specified disease plan; or

(ix) A long-term-care-only plan;

(2) "Healthcare professional" means a person who is licensed, certified, or otherwise authorized by the laws of this state to administer health care in the ordinary course of the practice of his or her profession;

(3) "Newborn" means a child who is twenty-nine (29) days of age or younger; and

(4) "Spinal muscular atrophy" means a genetic disease that affects the part of the nervous system that controls voluntary muscle movement.

History. Acts 2019, No. 58, § 2.

23-79-1802. Coverage for newborn screening for spinal muscular atrophy.

(a) A health benefit plan that is offered, issued, or renewed in this state shall provide coverage for newborn screening for spinal muscular atrophy by a healthcare professional on or after January 1, 2020.

(b) The coverage for newborn screening for spinal muscular atrophy under this section:

(1) Is not subject to policy deductibles or copayment requirements; and

(2) Does not diminish or limit benefits otherwise allowable under a health benefit plan.

History. Acts 2019, No. 58, § 2.

Subchapter 19 — Coverage for Services of Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections and Pediatric Acute-Onset Neuropsychiatric Syndrome

SECTION.

A.C.R.C. Notes. Acts 2019, No. 878, § 2, provided: "Arkansas PANS/PANDAS Advisory Council — Creation — Duties.

"(a) The Arkansas PANS/PANDAS Advisory Council is created.

"(b) The Arkansas PANS/PANDAS Advisory Council shall be composed of the following members:

"(1) Two (2) members of the House of Representatives appointed by the Speaker of the House of Representatives;

"(2) Two (2) members of the Senate appointed by the President Pro Tempore of the Senate;

"(3) One (1) member who is a medical professional with two (2) years of professional experience working with PANS/PANDAS patients, appointed by the Governor;

"(4) One (1) member who is a medical professional with two (2) years of professional experience working with PANS/PANDAS patients, appointed by the Arkansas PANS/PANDAS Advisory Council;

"(5) The Director of the Department of Health or his or her designee, serving as an ex officio nonvoting member;

"(6) The Insurance Commissioner or his or her designee, serving as an ex officio nonvoting member;

"(7) Three (3) members who are employed by a public school district appointed by the Governor, one (1) member to be a public school nurse, one (1) member to be a public school counselor, and one (1) member to be a public school teacher;

"(8) One (1) member who is designated by the Arkansas Hospital Association, Inc.;

"(9) One (1) member who is designated by the Arkansas State Board of Nursing;

"(10) One (1) member who is designated by the Arkansas Pharmacist's Association;

"(11) One (1) member who is designated by the American Academy of Allergy, Asthma, and Immunology;

"(12) Two (2) members who are parents, appointed by the Governor; and

"(13) One (1) member who is designated by the Arkansas Medical, Dental, and Pharmaceutical Association, Inc.

"(c) The terms of the members of the Arkansas PANS/PANDAS Advisory Council shall expire on December 31, 2020.

"(d) Members shall serve at the pleasure of the organizations they represent or of the Governor, as indicated.

"(e) Vacancies on the Arkansas PANS/PANDAS Advisory Council shall be filled in the same manner as provided for the initial appointment.

"(f) The chair and vice-chair of the Arkansas PANS/PANDAS Advisory Council shall be one (1) of the legislative members of the interdisciplinary panel and shall be selected by the members of the interdisciplinary panel.

"(g) The Arkansas PANS/PANDAS Advisory Council shall meet as often as is deemed necessary by the chair.

"(h) All members of the Arkansas PANS/PANDAS Advisory Council shall serve without compensation and shall not receive per diem, mileage, or stipends.

"(i) The Arkansas PANS/PANDAS Advisory Council shall receive staff support from the Bureau of Legislative Research.

"(j) The Arkansas PANS/PANDAS Advisory Council may:

"(1) Make recommendations designed to improve and increase knowledge and develop mechanisms to increase clinical awareness and treatment throughout the state for pediatric acute-onset neuropsychiatric syndrome, also known as 'PANS', and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection, also known as 'PANDAS', especially for healthcare professionals;

"(2) Operate along with the interdisciplinary panel at the University of Arkansas for Medical Sciences to determine quarterly information, including case statistics, outcome measures, and other relevant information;

"(3) Make recommendations concerning standard practice guidelines for the diagnosis and treatment of PANS/PANDAS;

"(4) Provide outreach to educators and parents; and

"(5) Develop a network of volunteer experts on PANS/PANDAS to serve as resources within this state.

"(k)(1) The Arkansas PANS/PANDAS Advisory Council shall submit a report to the Legislative Council, the Senate Committee on Insurance and Commerce, the House Committee on Insurance and Commerce, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor no later than August 31, 2019.

"(2) The Arkansas PANS/PANDAS Advisory Council shall report to the Senate Committee on Insurance and Commerce, the House Committee on Insurance and Commerce, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor as requested.

"(l) This section expires December 31, 2020".

23-79-1901. Findings.

The General Assembly finds that:

(1) Pediatric acute-onset neuropsychiatric syndrome, also known as "PANS", is a clinically defined disorder characterized by the sudden onset of obsessive-compulsive symptoms or eating restrictions, accompanied by two (2) or more symptoms of acute behavioral deterioration or motor and sensory changes, or both;

(2) Pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections, also known as "PANDAS", is a term used to describe a subset of children and adolescents within the broader PANS classification;

(3) Some insurance companies are currently providing disparate insurance coverage for the treatment of PANS and PANDAS, including

the State and Public School Life and Health Insurance Program, the University of Arkansas for Medical Sciences, Medicaid, and some insurance companies that serve the interests of Arkansans; and

(4) However, not all insurance providers in Arkansas provide coverage or sufficient coverage for PANS and PANDAS, and those insurance companies that do should be consistent in coverage of treatment of PANS and PANDAS.

History. Acts 2019, No. 878, § 1.

23-79-1902. Interdisciplinary panel — University of Arkansas for Medical Sciences.

(a) The University of Arkansas for Medical Sciences has partnered with Arkansas Children's Hospital and the National Institute of Mental Health for the establishment and operation of a clinic that currently serves patients with pediatric acute-onset neuropsychiatric syndrome, also known as "PANS", and pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections, also known as "PANDAS".

(b)(1) The University of Arkansas for Medical Sciences shall organize an interdisciplinary panel incorporating all components of those affected by PANS/PANDAS, including without limitation working with national organizations.

(2) The interdisciplinary panel under subdivision (b)(1) of this section shall include:

(A) A member at large from the Arkansas PANS/PANDAS Advisory Council;

(B) A member at large who is a medical professional with a minimum experience of two (2) years working with PANS/PANDAS patients and who is recommended by the Arkansas PANS/PANDAS Advisory Council with final approval by the University of Arkansas for Medical Sciences; and

(C) A member at large who is a medical director or medical officer from an insurance company licensed in this state to assist in the development of diagnostic criteria for future insurance coverage purposes.

(c) An interdisciplinary team shall be established to create a protocol for the treatment of and diagnostic framework for the coverage of PANS and PANDAS by June 1, 2019, to allow for the assignment of an International Classification of Diseases code, such as an ICD-9 code or other applicable medical code for insurance coverage purposes.

(d) The interdisciplinary team shall report to the Senate Committee on Public Health, Welfare, and Labor, the House Committee on Public Health, Welfare, and Labor, the Senate Committee on Insurance and Commerce, and the House Committee on Insurance and Commerce no later than August 31, 2019.

(e) Once the interdisciplinary team determines appropriate diagnostic criteria for the protocol, a final report with recommendations shall

be submitted to the Senate Committee on Public Health, Welfare, and Labor, the House Committee on Public Health, Welfare, and Labor, the Senate Committee on Insurance and Commerce, the House Committee on Insurance and Commerce, and the General Assembly to include recommendations concerning mandating insurance coverage for the treatment of PANS and PANDAS for the next scheduled regular session that convenes after the submission of the report or the Governor is encouraged to add the recommendation to the call of any special session that is convened before the next scheduled regular session.

(f) The expectation for the interdisciplinary team is that:

(1) Every available tool will be utilized to make healthcare services for the treatment of PANS and PANDAS available statewide through the University of Arkansas for Medical Sciences network and available services, including telemedicine; and

(2) Once the interdisciplinary team determines the diagnostic criteria for purposes of insurance coverage, all insurance companies and health benefit plans that are licensed in this state shall provide coverage for the treatment of PANS and PANDAS diagnosed according to the established diagnostic criteria recommended by the interdisciplinary team.

(g) The goal of the interdisciplinary team is to have the diagnostic criteria finalized and ready to be presented at the December 2019 meeting of the Senate Committee on Public Health, Welfare, and Labor, the House Committee on Public Health, Welfare, and Labor, the Senate Committee on Insurance and Commerce, and the House Committee on Insurance and Commerce.

History. Acts 2019, No. 878, § 1.

Subchapter 20 — Healthcare Payor Identification Card Act

Effective Dates. Acts 2019, No. 706, § 2: Apr. 4, 2019. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that there is confusion in the marketplace among consumers and providers as to whether members are in an insured or self-funded plan; that simply identifying the type of plan on a member's identification card will significantly address this problem without causing an administrative burden; and that this act is immediately necessary because the confusion makes proper regulation and enforcement of laws under the Arkansas Insurance Code difficult. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto".

23-79-2001. Title.

This subchapter shall be known and may be cited as the "Healthcare Payor Identification Card Act".

History. Acts 2019, No. 706, § 1.

23-79-2002. Definitions.

As used in this subchapter:

(1)(A) "Health benefit plan" means an individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by a healthcare payor in this state.

(B) "Health benefit plan" does not include workers' compensation plans, Medicaid, or a plan that provides only dental benefits or eye and vision care benefits;

(2)(A) "Healthcare payor" means an entity or individual that contracts, pays, or arranges for payment, in whole or in part, for the delivery of healthcare services or products that are covered by a health benefit plan administered, issued, or delivered by the entity or individual.

(B) "Healthcare payor" includes a health insurance company, a health maintenance organization, a hospital and medical services corporation, and an entity that provides or administers a self-funded health benefit plan, including a governmental plan;

(3) "Identification card" means a card or other technology that functions like a card issued by a healthcare payor to a subscriber or member and containing information related to the member's identity and health benefit plan; and

(4) "Member" means an individual enrolled or subscribed for healthcare services or products that are covered by a health benefit plan.

History. Acts 2019, No. 706, § 1.

23-79-2003. Identification cards.

A healthcare payor shall issue an identification card to a member that provides an indication of whether the health benefit plan is insured or self-funded.

History. Acts 2019, No. 706, § 1.

CHAPTER 80

INSURANCE POLICIES — SIMPLIFICATION

SUBCHAPTER.

2. Life and Accident and Health Insurance Policy Language Simplification Act.
3. Property and Casualty Insurance Policy Simplification Act.
4. Prescription Drug Paperwork Simplification.

Subchapter 2 — Life and Accident and Health Insurance Policy Language Simplification Act

SECTION.

23-80-206. Minimum standards.

(a) In addition to any other requirements of law, no policy forms, except as stated in § 23-80-204, shall be delivered or issued for delivery in this state on or after the dates forms must be approved under this subchapter, unless:

(1) The text achieves a minimum score of forty (40) on the Flesch reading ease test or an equivalent score on any other comparable test as provided in subsection (c) of this section;

(2) It is printed, except for specification pages, schedules, and tables, in not less than 10-point type, 1-point leaded;

(3) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsements or riders; and

(4) It contains a table of contents or an index of the principal sections of the policy, if the policy has more than three thousand (3,000) words printed on three (3) or fewer pages of text, or if the policy has more than three (3) pages, regardless of the number of words.

(b)(1) For the purposes of this section, a Flesch reading ease test score shall be measured by the following method:

(A) For policy forms containing ten thousand (10,000) words or less, the entire form shall be analyzed. For policy forms containing more than ten thousand (10,000) words, the readability of two (2) two-hundred-word samples per page may be analyzed instead of the entire form. The samples shall each be separated by at least ten (10) printed lines;

(B) The number of words and sentences in the text shall be counted, and then the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1.015;

(C) The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6; and

(D) The sum of the figures computed under subdivisions (b)(1)(B) and (C) of this section subtracted from 206.835 equals the Flesch reading ease score for the policy form.

(2) For purposes of subdivisions (b)(1)(B)-(D) of this section, the following procedures shall be used:

(A) A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one (1) word;

(B) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence; and

(C)(i) A syllable means a unit of spoken language consisting of one (1) or more letters or a word as divided by an accepted dictionary.

(ii) When the dictionary shows two (2) or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

(3) The term "text" as used in this section shall include all printed matter except the following:

(A) The name and address of the insurer, the name, number, or title of the policy, the table of contents or index, captions and subcaptions, and specification pages, schedules, or tables; and

(B) Any policy language which is drafted to conform to the requirements of any federal law, regulation, or agency interpretation, any policy language required by any collectively bargained agreement, any medical terminology, any words which are defined in the policy, and any policy language required by law or rule, provided that the insurer identifies the language or terminology excepted by this subdivision (b)(3) and certifies in writing that the language or terminology is entitled to be excepted by this subdivision (b)(3).

(c) Any other reading test may be approved by the Insurance Commissioner for use as an alternative to the Flesch reading ease test if it is comparable in result to the Flesch reading ease test.

(d)(1) Filings subject to this section shall be accompanied by a certificate signed by an officer of the insurer stating that it meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved in accordance with § 23-80-207.

(2) To confirm the accuracy of any certification, the commissioner may require the submission of further information to verify the certification in question.

(e) At the option of the insurer, riders, endorsements, applications, and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

History. Acts 1979, No. 258, § 5; A.S.A. 1947, § 66-3255; Acts 2019, No. 315, § 2722.

Amendments. The 2019 amendment substituted "rule" for "regulation" in (b)(3)(B).

23-80-207. Authorization to use lower score.

The Insurance Commissioner may authorize a lower score than the Flesch reading ease score required in § 23-80-206(a)(1) whenever, in the commissioner's discretion, he or she finds that a lower score:

(1) Will provide a more accurate reflection of the readability of a policy form;

(2) Is warranted by the nature of a particular policy form or type or class of policy forms; or

(3) Is caused by certain policy language which is drafted to conform to the requirements of any state law, rule, or agency interpretation.

History. Acts 1979, No. 258, § 7; A.S.A. 1947, § 66-3257; Acts 2019, No. 315, § 2723.

Amendments. The 2019 amendment substituted "rule" for "regulation" in (3).

Subchapter 3 — Property and Casualty Insurance Policy Simplification Act

SECTION.

23-80-305. Powers of commissioner.

(a) After notice and hearing, the Insurance Commissioner may issue reasonable rules implementing §§ 23-80-306 and 23-80-308.

(b) At the commissioner's sole discretion, he or she may extend any dates under this subchapter.

(c) The commissioner shall have sole authority to enforce the provisions of this subchapter or seek remedies for its violation.

History. Acts 1981, No. 517, § 8; A.S.A. 1947, § 66-5808; Acts 2019, No. 315, § 2724.

Amendments. The 2019 amendment deleted "or regulations" following "rules" in (a).

23-80-306. Minimum standards.

(a) All policies which, under subsection (b) of this section, must comply with this subsection shall be simplified, taking into consideration the following factors:

(1) Use of simple sentence structure and short sentences;

(2) Use of commonly understood words;

(3) Avoidance of technical legal terms whenever possible;

(4) Minimal reference to other sections or provisions of the policy;

(5) Organization of text; and

(6) Legibility.

(b)(1)(A) In addition to any other requirements of law, the Insurance Commissioner shall by rule specify the dates by which personal lines policies shall comply with subsection (a) of this section.

(B) The dates established by the commissioner for compliance shall not be less than eighteen (18) months nor more than thirty-six (36) months from the effective date of the rule.

(C) "Personal lines policies" are policies:

(i) Solely used to provide homeowners' insurance, dwelling fire insurance on one (1) to four (4) family units, or individual fire insurance on dwelling contents; or

(ii) Principally used to provide primary insurance on private passenger nonfleet automobiles individually owned and used for personal or family needs.

(2) In addition to any other requirements of law, the commissioner may by rules specify which policies, other than those described in subdivision (b)(1) of this section, shall comply with subsection (a) of this

section. The dates, if any, established by the commissioner for compliance may not be less than forty-eight (48) months from June 17, 1981, or twenty-four (24) months from the effective date of the rule establishing the dates, whichever is later.

History. Acts 1981, No. 517, §§ 5, 6; A.S.A. 1947, §§ 66-5805, 66-5806; Acts 2019, No. 315, § 2725.

Amendments. The 2019 amendment substituted "rule" for "regulation" in (b)(1)(A); and substituted "rules" for "regulations" in (b)(2).

Subchapter 4 — Prescription Drug Paperwork Simplification

SECTION.
23-80-409. Enabling clause.

23-80-409. Enabling clause.

The Insurance Commissioner shall promulgate rules necessary to implement this subchapter and shall look for guidance to the standards and implementation guides produced by the National Council for Prescription Drug Programs.

History. Acts 2001, No. 1409, § 9; 2019, No. 315, § 2726.

Amendments. The 2019 amendment substituted "rules" for "regulations".

CHAPTER 81

LIFE INSURANCE POLICIES AND ANNUITIES

SUBCHAPTER.
2. Standard Nonforfeiture Law for Life Insurance.
3. Standard Nonforfeiture Law For Individual Deferred Annuities.
4. Variable Contracts.
9. Unclaimed Life Insurance Benefits Act.

Subchapter 2 — Standard Nonforfeiture Law for Life Insurance

SECTION.
23-81-201. Title.
23-81-209. Calculation of adjusted premiums and present values — All policies issued on or after operative date of § 23-81-213(d).
23-81-210. Calculation of future adjusted premiums.

23-81-201. Title.

This subchapter shall be known and may be cited as the "Standard Nonforfeiture Law for Life Insurance".

History. Acts 1959, No. 148, § 336; 1977, No. 550, § 1; 1981, No. 535, § 2; A.S.A. 1947, § 66-3327; Acts 2015, No. 1223, § 32.

Amendments. The 2015 amendment inserted "and may be cited".

23-81-209. Calculation of adjusted premiums and present values — All policies issued on or after operative date of § 23-81-213(d).

(a)(1) This section shall apply to all policies issued on or after the operative date of § 23-81-213(d) as defined therein.

(2) Except as provided in subsection (g) of this section, the adjusted premiums for any policy shall be calculated on an annual basis and shall be the uniform percentage of the respective premiums specified in the policy for each policy year, excluding:

(A) Amounts payable as extra premiums to cover impairments or special hazards; and

(B) Any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of:

(i) The then-present value of the future guaranteed benefits provided for by the policy;

(ii) One percent (1%) of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years; and

(iii) One hundred twenty-five percent (125%) of the nonforfeiture net level premium as defined in this section.

(3) However, in applying the percentage specified in subdivision (a)(2)(B)(iii) of this section, no nonforfeiture net level premium shall be deemed to exceed four percent (4%) of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years.

(4) The date of issue of a policy for the purpose of this subchapter shall be the date as of which the rate age of the insured is determined.

(b) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one (1) per annum, payable on the date of issue of the policy and on each anniversary of the policy on which a premium falls due.

(c) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any change in the benefits or premiums, the future adjusted premiums, nonforfeiture net level premiums, and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(d) Except as otherwise provided in subsection (g) of this section, the recalculated future adjusted premiums for any policy shall be a uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all future adjusted premiums shall be equal to the excess of:

(1) The sum of the then-present value of the then-future guaranteed benefits provided for by the policy and the additional expense allowance, if any; over

(2) The then-cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(e) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of:

(1) One percent (1%) of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten (10) policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten (10) policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and

(2) One hundred twenty-five percent (125%) of the increase, if positive, in the nonforfeiture net level premium.

(f) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing subdivisions (d)(1) and (2) of this section when:

(1) Subdivision (d)(2) of this section equals the sum of:

(A) The nonforfeiture net level premium applicable prior to the change multiplied by the present value of an annuity of one (1) per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred; and

(B) The present value of the increase in future guaranteed benefits provided by the policy;

(2) Subdivision (d)(2) of this section equals the present value of an annuity of one (1) per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(g) Notwithstanding any other provisions of this section to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, the policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for the substandard policy may be calculated as if it were issued to provide higher uniform amounts of insurance on the standard basis.

(h)(1) All adjusted premiums and present values referred to in this subchapter shall:

(A) For all policies of ordinary insurance, be calculated on the basis of the Commissioner's 1980 Standard Ordinary Mortality Table or at the election of the insurer for any one (1) or more specified plans of life insurance, the Commissioner's 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors;

(B) For all policies of industrial insurance, be calculated on the basis of the Commissioner's 1961 Standard Industrial Mortality Table; and

(C) For all policies issued in a particular calendar year, be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this section, for policies issued in that calendar year.

(2) However:

(A) At the option of the insurer, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this subchapter, for policies issued in the immediately preceding calendar year;

(B) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available whether or not required by § 23-81-203 shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of the paid-up nonforfeiture benefit and paid-up dividend additions, if any;

(C) An insurer may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values;

(D) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioner's 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioner's 1961 Industrial Extended Terms Insurance Table for policies of industrial insurance;

(E) For insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables;

(F)(i) For a policy issued before the operative date of the valuation manual, any Commissioner's Standard Ordinary Mortality Table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule promulgated by the Insurance Commissioner for use in determining the minimum nonforfeiture standard may be substituted for the 1980 Commissioner's Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the 1980 Commissioner's Extended Term Insurance Table.

(ii) For a policy issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commis-

sioner's Standard Ordinary Mortality Table for use in determining the minimum nonforfeiture standard that may be substituted for the 1980 Commissioner's Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the 1980 Commissioner's Extended Term Insurance Table.

(iii) If the Insurance Commissioner approves by rule any Commissioner's Standard Ordinary Mortality Table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard shall supersede the minimum nonforfeiture standard provided by the valuation manual;

(G)(i) For a policy issued before the operative date of the valuation manual, any Commissioner's Standard Industrial Mortality Table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule promulgated by the Insurance Commissioner for use in determining the minimum nonforfeiture standard may be substituted for the 1961 Commissioner's Standard Industrial Mortality Table or the 1961 Commissioner's Industrial Extended Term Insurance Table.

(ii) For a policy issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioner's Standard Industrial Mortality Table for use in determining the minimum nonforfeiture standard that may be substituted for the 1961 Commissioner's Standard Industrial Mortality Table or the 1961 Commissioner's Industrial Extended Term Insurance Table.

(iii) If the Insurance Commissioner approves by rule any Commissioner's Standard Industrial Mortality Table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual;

(H)(i) For a policy issued before the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred twenty-five percent (125%) of the calendar year statutory valuation interest rate for the policy as defined in this subchapter, rounded to the nearest one-quarter of one percent (0.25%), provided the nonforfeiture interest rate shall not be less than four percent (4%).

(ii) For a policy issued on and after the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be provided by the valuation manual; and

(I) Notwithstanding any other provision in this code to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute

nonforfeiture values shall not require refiling of any other provisions of that policy form.

History. Acts 1959, No. 148, § 336; 1981, No. 535, § 2; A.S.A. 1947, § 66-3327; Acts 2015, No. 1223, §§ 33-35; 2019, No. 315, §§ 2727, 2728.

Amendments. The 2015 amendment inserted designation (h)(2)(F)(i); added (h)(2)(F)(ii) and (iii); inserted designation (h)(2)(G)(i); added (h)(2)(G)(ii) and (iii); in (h)(2)(F)(i) and (h)(2)(G)(i), substituted "For a policy issued before the operative date of the valuation manual, any Commissioner's Standard" for "Any"; substituted "1980 Commissioner's" for "commissioner's 1980" twice in (h)(2)(F)(i); substituted "1961 Commissioner's" for "commissioner's 1961" twice in (h)(2)(G)(i); inserted designation (h)(2)(H)(i); added (h)(2)(H)(ii); and in (h)(2)(H)(i), added "For a policy issued before the operative date of the valuation manual" and added "provided the nonforfeiture interest rate shall not be less than four percent (4%)".

The 2019 amendment substituted "rule" for "regulation" in (h)(2)(F)(i); and substituted "rules" for "regulations" in (h)(2)(G)(i).

23-81-210. Calculation of future adjusted premiums.

(a) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in §§ 23-81-203 — 23-81-209:

(1) The Insurance Commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by §§ 23-81-203 — 23-81-209;

(2) The commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds; and

(3) The cash surrender values and paid-up nonforfeiture benefits provided by the plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this subchapter, as determined by rules promulgated by the commissioner.

(b) Notwithstanding any other provision in the laws of the state, any policy, contract, or certificate providing life insurance under any plan must be affirmatively approved by the commissioner before it can be marketed, issued, delivered, or used in this state.

History. Acts 1959, No. 148, § 336; 1981, No. 535, § 2; A.S.A. 1947, § 66-3327; Acts 2019, No. 315, § 2729.

Amendments. The 2019 amendment substituted "rules" for "regulations" in (a)(3).

Subchapter 3 — Standard Nonforfeiture Law For Individual Deferred Annuities

SECTION.

23-81-313. Rules.

The Insurance Commissioner may adopt rules to implement the provisions of this subchapter.

History. Acts 2005, No. 506, § 43; 2019, No. 315, § 2730.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in the section heading and the text.

Subchapter 4 — Variable Contracts

SECTION.

23-81-402. Provisions for allocation of income.

A domestic life insurance company may establish one (1) or more separate accounts and may allocate thereto amounts including, without limitation, proceeds applied under optional modes of settlement or under dividend options to provide for life insurance or annuities, and benefits incidental thereto, payable in fixed or variable amounts, or subject to a market value adjustment as provided in rules adopted by the Insurance Commissioner, subject to the following:

(1) The income, gains, and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the account without regard to other income, gains, or losses of the company or to any other separate account of the company;

(2) Except as may be provided with respect to reserves for guaranteed benefits and funds referred to in subdivision (3) of this section, amounts allocated to any separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments of life insurance companies. The investments in the separate accounts shall not be considered when applying the investment limitations otherwise applicable to the investments of the company;

(3) Except with the approval of the commissioner and under such conditions as to investments and other matters as the commissioner may prescribe which shall recognize the guaranteed nature of the benefits provided, reserves for benefits guaranteed as to dollar amount and duration and funds guaranteed as to principal amount or stated rate of interest shall not be maintained in a separate account;

(4)(A) Unless otherwise approved by the commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation, with the exception of separate accounts supporting modified guaranteed annuities which shall be valued as provided in such rules as the commissioner shall adopt, or, if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to the separate account.

(B) However, unless approved by the commissioner, the portion of any of the assets of the separate account equal to the company's reserve liability with regard to the guaranteed benefits and funds referred to in subdivision (3) of this section shall be valued in accordance with the rules otherwise applicable to the company's assets;

(5)(A) Amounts allocated to a separate account in the exercise of the power granted by this subchapter shall be owned by the company. The company shall not be, nor hold itself out to be, a trustee with respect to the amounts.

(B)(i) If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to the account shall not be chargeable with liabilities arising out of any other business the company may conduct.

(ii) However, in no event shall the assets in a separate account for support of modified guaranteed annuity contracts subject to a market adjustment as provided in this section be immune from liabilities arising out of any other business the company conducts;

(6)(A) No sale, exchange, or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one (1) or more of its separate accounts unless, in case of a transfer into a separate account, the transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such a transfer, whether into or from a separate account, is made by a transfer of cash or by a transfer of securities having a readily determinable market value, provided that the transfer of securities is approved by the commissioner.

(B) The commissioner may approve other transfers among accounts if, in the commissioner's opinion, the transfers would not be inequitable; and

(7) To the extent the company deems it necessary to comply with any applicable federal or state laws, the company, with respect to any separate account, including, without limitation, any separate account which is a management investment company or a unit investment trust, may provide for persons having an interest therein appropriate voting and other rights and special procedures for the conduct of the business of the account, including, without limitation, special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and the selection of a committee, the members of which need not be otherwise affiliated with the company, to manage the business of the account.

History. Acts 1975, No. 728, § 1; A.S.A. 1947, § 66-3337; Acts 1993, No. 901, § 41; 2019, No. 315, § 2731.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in the introductory language and in (4)(A).

Subchapter 7 — Structured Settlement Protection Act

23-81-702. Definitions.

CASE NOTES

Interested Parties.

Even though they were not parties to a case, an insurer and obligor had standing to appeal an order relating to a structured settlement agreement because they were clearly interested parties under this section; the agreement provided that a company was paid a sum of money to fund periodic payments through the purchase of an annuity. Metro. Life Ins. Co. v. B.J.L.Y., LLC, 2016 Ark. App. 201, 489 S.W.3d 210 (2016).

23-81-704. Approval of transfers of structured settlement payment rights.

CASE NOTES

Violation.

Transfer of periodic payments from a structured settlement agreement violated the Structured Settlement Protection Act's prohibition on dividing periodic payments between the payee of a structured settlement agreement and a transferee of periodic payments; the order directed the payment of the entire sum to an assignee and instructed the assignee to distribute the payee's share. Metro. Life Ins. Co. v. B.J.L.Y., LLC, 2016 Ark. App. 201, 489 S.W.3d 210 (2016).

23-81-705. Effects of transfer of structured settlement payment rights.

CASE NOTES

Violation.

Transfer of periodic payments from a structured settlement agreement violated the Structured Settlement Protection Act's prohibition on dividing periodic payments between the payee of a structured settlement agreement and a transferee of periodic payments; the order directed the payment of the entire sum to an assignee and instructed the assignee to distribute the payee's share. Metro. Life Ins. Co. v. B.J.L.Y., LLC, 2016 Ark. App. 201, 489 S.W.3d 210 (2016).

23-81-706. Procedure for approval of transfers.

CASE NOTES

Interested Parties.

Even though they were not parties to a case, an insurer and obligor had standing to appeal an order relating to a structured settlement agreement because they were clearly interested parties under § 23-81-702; the agreement provided that a company was paid a sum of money to fund periodic payments through the purchase of an annuity. Metro. Life Ins. Co. v. B.J.L.Y., LLC, 2016 Ark. App. 201, 489 S.W.3d 210 (2016).

Subchapter 9 — Unclaimed Life Insurance Benefits Act

Publisher's Notes. Acts 2015, No. 905, § 2, provided: "Section 1 of this act is applicable to policies issued after June 30, 2016."

23-81-901. Title.

This subchapter shall be known and may be cited as the "Unclaimed Life Insurance Benefits Act".

History. Acts 2015, No. 905, § 1.
Publisher's Notes. Acts 2015, No. 905, § 2, provided: "Section 1 of this act is applicable to policies issued after June 30, 2016."

23-81-902. Legislative intent.

The General Assembly intends for this subchapter to:

(1) Recognize the escheat or unclaimed property statutes under the Unclaimed Property Act, § 18-28-201 et seq.; and

(2) Require the complete and proper disclosure, transparency, and accountability for any method of payment of death benefits under a life insurance policy that is subject to regulation by the State Insurance Department.

History. Acts 2015, No. 905, § 1.
Publisher's Notes. Acts 2015, No. 905, § 2, provided: "Section 1 of this act is applicable to policies issued after June 30, 2016."

23-81-903. Definitions.

As used in this subchapter:

(1)(A) "Contract" means an annuity contract.

(B) "Contract" does not include:

(i) An annuity contract used to fund an employment-based retirement plan or program in which an insurer:

(a) Does not perform recordkeeping services; or

(b) Is not required to pay death benefits to the beneficiaries of a specific plan participant by terms of the annuity contract; or

(ii) An annuity used to fund a funeral or related expenses or a prepaid funeral benefits contract;

(2) "Death master file" means a comprehensive database or source of death information used to verify the death of an individual maintained by the Division of Vital Records, the Social Security Administration, or other database or service;

(3) "Death master file match" means locating a Social Security number or the name and date of birth of an insured, annuity owner, or retained asset account holder in a search of a death master file;

(4) "Knowledge of death" means:

(A) Receipt of an original or valid copy of a death certificate issued by the state or a political subdivision of the state; or

(B) A death master file match validated by an insurer under § 23-81-904(c)(1)(A);

(5)(A) "Policy" means a policy or certificate of life insurance issued in this state that provides a death benefit.

(B) "Policy" does not include:

(i) A policy or certificate of life insurance that provides a death benefit under:

(a) A defined employee benefit pension plan, as defined in section 3(35) of the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406; or

(b) Any federal employee benefit program;

(ii) A policy or certificate of life insurance that is used to fund a funeral or related expenses or a prepaid funeral benefits contract;

(iii) A policy or certificate of credit life or accidental death insurance; or

(iv) A policy issued to a group master policyholder for which the insurer does not provide recordkeeping services;

(6) "Recordkeeping services" means services under a group policy or contract between an insurer and a group policy or contract customer to obtain, maintain, and administer on behalf of the insured a list of the individuals who are insured under a group insurance contract or a line of coverage, including an individual's:

(A) Social Security number or name and date of birth;

(B) Beneficiary designation information;

(C) Coverage eligibility;

(D) Benefit amount; and

(E) Premium payment status; and

(7) "Retained asset account" means a mechanism to deposit the settlement of proceeds payable under a policy or contract into a deposit account where the proceeds are retained by the insurer or its agent under a supplementary contract that only involves death benefits.

History. Acts 2015, No. 905, § 1; 2017, No. 368, §§ 1, 2.

Publisher's Notes. Acts 2015, No. 905, § 2, provided: "Section 1 of this act is applicable to policies issued after June 30, 2016."

Amendments. The 2017 amendment redesignated the former introductory language in (1)(B) as present (1)(B) and (1)(B)(i); redesignated former (1)(B)(i) and (1)(B)(ii) as (1)(B)(i)*(a)* and (1)(B)(i)*(b)*; added present (1)(B)(ii); substituted "funeral or related expenses or a prepaid funeral benefits contract" for "preneed funeral contract or prearrangement" in (5)(B)(ii); and made stylistic changes.

23-81-904. Insurer conduct.

(a) An insurer shall make a good faith effort to determine the death of an insured upon receipt of knowledge of death.

(b)(1) An insurer shall compare an in-force policy, contract, and retained asset account against a death master file to identify a potential match to an insured covered under the policy, contract, and retained asset account by using the full version of the death master file.

(2) An insurer shall perform the comparison under subdivision (b)(1) of this section semiannually by using the death master file update.

(c)(1) For a potential match that is identified as a result of a death master file match, the insurer shall within ninety (90) days of a death master file match:

(A) Make and document a good faith effort to confirm the death of the insured or retained asset account holder against other available records and information;

(B) Determine if death benefits are due under an applicable policy or contract; and

(C) If death benefits are due under the applicable policy or contract:

(i) Make a good faith effort to document and locate any beneficiary or beneficiaries; and

(ii) Provide the beneficiary or beneficiaries the necessary claim form or instructions to make a claim under the policy or contract, including submitting a death certificate issued by the state or any political subdivision of the state if required under the policy or contract.

(2) If an insurer is unable to confirm the death of an individual under subdivision (c)(1) of this section, the policy, annuity, or retained asset account may be considered by an insurer to be in force according to the terms of the policy, annuity, or retained asset account.

(3) An insurer is required to confirm a possible death of an insured under a group life insurance if the insurer maintains for an individual covered under a policy or certificate an insured's:

(A) Social Security number or name and date of birth;

(B) Beneficiary designation information;

(C) Coverage eligibility;

(D) Benefit amount; and

(E) Premium payment status.

(4) To the extent permitted by law, an insurer may disclose the necessary personal information about an insured or beneficiary to a person who the insurer reasonably believes may be able to assist the insurer in locating a beneficiary or a person entitled to payment of the claims proceeds.

(d) An insurer shall not charge a beneficiary or the beneficiary's authorized representative a fee or charge any costs associated with a death master file search or verification of a death master file match performed under this section.

(e)(1) A benefit or any accrued contractual interest under a policy, contract, or a retained asset account is payable to the designated beneficiary or owner.

(2) If a beneficiary or owner cannot be found, the benefit or any accrued contractual interest shall escheat to the state as unclaimed property under the Unclaimed Property Act, § 18-28-201 et seq.

(3) Interest payable under § 23-81-118 shall not be payable as unclaimed property under the Unclaimed Property Act, § 18-28-201 et seq.

(f) An insurer shall notify the Auditor of State upon the expiration of the statutory time period for escheat that:

(1) A beneficiary under a life insurance policy, contract, or retained asset account holder has not submitted a claim with the insurer; and

(2) The insurer has complied with subsection (b) of this section and has documented its good faith effort to locate and notify a beneficiary or retained asset account holder but has been unsuccessful.

(g) Upon delivery of a notice under subsection (f) of this section, an insurer shall submit immediately any unclaimed benefits under a policy, contract, or retained asset account, plus any applicable interest, to the Auditor of State.

History. Acts 2015, No. 905, § 1.

Publisher's Notes. Acts 2015, No. 905, § 2, provided: "Section 1 of this act is applicable to policies issued after June 30, 2016."

23-81-905. Unfair trade practices.

(a) If an insurer fails to comply with this subchapter so frequently as to be a general business practice, then it is a violation of this subchapter and may be subject to the Trade Practices Act, § 23-66-201 et seq.

(b) A violation of this subchapter does not create a private right of action.

History. Acts 2015, No. 905, § 1.

Publisher's Notes. Acts 2015, No. 905, § 2, provided: "Section 1 of this act is applicable to policies issued after June 30, 2016."

CHAPTER 83

GROUP LIFE INSURANCE AND ANNUITIES

SECTION.

23-83-107. Restrictions on coverage of other groups.

Group insurance offered to a resident of this state under a group policy issued to a group other than one described in §§ 23-83-102 — 23-83-106 shall be subject to the following requirements:

(1) No group policy or certificate shall be delivered in this state unless the Insurance Commissioner finds that:

(A) The issuance of the group policy is not contrary to the best interest of the public;

(B) The issuance of the group policy would be actuarially sound;

(C) The issuance of the group policy would result in economies of acquisition or administration; and

(D) The benefits are reasonable in relation to the premiums charged;

(2) The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both;

(3) The commissioner may issue rules implementing the requirements of subdivision (1) of this section; and

(4) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

History. Acts 1981, No. 898, § 7; A.S.A. 1947, § 66-3507; Acts 1987, No. 254, § 1; 2019, No. 315, § 2732.

Amendments. The 2019 amendment substituted "rules" for "regulations" in (3).

CHAPTER 84

STANDARD VALUATION LAW FOR LIFE INSURANCE AND ANNUITIES

SECTION.

23-84-101. Title — Definitions.

(a) This chapter shall be known and may be cited as the "Standard Valuation Law for Life Insurance and Annuities".

(b) As used in this chapter:

(1) "Accident and health insurance" means:

(A) A contract that incorporates morbidity risk and provides protection against economic loss resulting from accident, sickness, or medical conditions; and

(B) The definition or description of "accident and health insurance" specified in the valuation manual;

(2) "Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required by § 23-84-112(b);

(3) "Company" means an entity that has written, issued, or reinsured a policy or contract:

(A) In this state and has at least one (1) policy or contract in force or in claim status; or

(B) In any state and is required to hold a certificate of authority to write a policy or contract in this state;

(4) "Deposit-type contract" means:

(A) A contract that does not incorporate mortality or morbidity risks; and

(B) The definition or description of "deposit-type contract" specified in the valuation manual;

(5) "Life insurance" means:

(A) A contract that incorporates mortality risk, including annuity and pure endowment contracts; and

(B) The definition or description of "life insurance" specified in the valuation manual;

(6) "Operative date of the valuation manual" means the date if approved by the Insurance Commissioner as the date for use under this chapter of the valuation manual or a change to the valuation manual that is:

(A) January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(i) The valuation manual has been adopted by the National Association of Insurance Commissioners by an affirmative vote of at least forty-two (42) members or three-fourths (3/4) of the members voting, whichever is greater;

(ii) The Standard Valuation Law, as amended by the National Association of Insurance Commissioners in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than seventy-five percent (75%) of the direct premiums written as reported for 2008 for:

(a) Life, accident, and health annual statements;

(b) Health annual statements; and

(c) Fraternal annual statements; and

(iii) The Standard Valuation Law, as amended by the National Association of Insurance Commissioners in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two (42) of the following fifty-five (55) jurisdictions:

The fifty (50) states of the United States, American Samoa, the Virgin Islands of the United States, the District of Columbia, Guam, and Puerto Rico; or

(B) For a change to the valuation manual unless the change to the valuation manual specifies a later effective date, January 1 following the date when the change to the valuation manual has been adopted by the National Association of Insurance Commissioners by an affirmative vote representing:

(i) At least three-fourths (3/4) of the members of the National Association of Insurance Commissioners that vote on the change to the valuation manual, but not less than a majority of the total membership; and

(ii) Members of the National Association of Insurance Commissioners representing jurisdictions totaling greater than seventy-five percent (75%) of the direct premiums written as reported in the annual statements most recently available before the vote in subdivision (6)(B)(i) of this section for:

(a) Life, accident, and health annual statements;

(b) Health annual statements; and

(c) Fraternal annual statements;

(7) "Policy or contract" means life insurance, accident and health insurance, or a deposit-type contract;

(8) "Policyholder behavior" means any action a policyholder, contract holder, or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract, including without limitation lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract, but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract;

(9) "Principle-based valuation" means a reserve valuation that uses one (1) or more methods or one (1) or more assumptions determined by the insurer and is required to comply with § 23-84-116 as specified in the valuation manual;

(10) "Qualified actuary" means an individual who:

(A) Is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries' qualification standards for actuaries signing such statements; and

(B) Meets the requirements specified in the valuation manual;

(11) "Reserve" means the amount set aside by a company to cover all future liabilities under the company's policies or contracts;

(12) "Tail risk" means a risk that occurs because:

(A) The frequency of low probability events is higher than expected under a normal probability distribution; or

(B) Observed events of very significant size or magnitude exist; and

(13) "Valuation manual" means the manual of valuation instructions adopted by the National Association of Insurance Commissioners that is approved for use under this chapter by the commissioner.

History. Acts 1959, No. 148, § 92; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511; Acts 2015, No. 1223, § 36.

A.C.R.C. Notes. Acts 2015, No. 1223, § 26, provided: "The operative date of the valuation manual under Arkansas Code, Title 23, Chapter 84, is the first January 1 of the year after the valuation manual is effective."

Amendments. The 2015 amendment added "Definitions" in the section heading; added designation (a); inserted "and may be cited" in (a); and added (b).

23-84-102. Valuation of reserves by Insurance Commissioner.

(a) Except as provided in subdivision (a)(4) of this section, for a policy or contract issued before the operative date of the valuation manual:

(1)(A) The Insurance Commissioner shall annually value, or cause to be valued, the reserves for all outstanding life insurance issued by a company on or after January 1, 1960, and before the operative date of the valuation manual.

(B) In calculating the reserves, the commissioner may use group methods and approximate averages for fractions of a year or otherwise;

(2) In lieu of the valuation of the reserves required by this section of any foreign or alien insurer, the commissioner may accept any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when that valuation complies with the minimum standard provided in this section;

(3)(A) Sections 23-84-103 — 23-84-111, 23-84-113, and 23-84-114 apply to a policy or contract issued on or after January 1, 1960, and before the operative date of the valuation manual.

(B) Sections 23-84-115 and 23-84-116 do not apply to a policy or contract issued on or after January 1, 1960, and before the operative date of the valuation manual; and

(4) The minimum standard for the valuation of a policy or contract issued before January 1, 1960, is the minimum standard in effect immediately before January 1, 1960.

(b) With regard to a policy or contract issued on or after the operative date of the valuation manual:

(1)(A) The commissioner shall annually value or cause to be valued the reserves for all outstanding policies or contracts of a company issued on or after the operative date of the valuation manual.

(B) In lieu of the valuation of the reserves required of a foreign or alien company, the commissioner may accept a valuation made or caused to be made by the public official or regulatory authority responsible for regulating insurance companies of another state or jurisdiction if the valuation complies with the minimum standard provided by this chapter; and

(2) Sections 23-84-114 — 23-84-116 shall apply.

History. Acts 1959, No. 148, § 92; 1977, No. 551, § 1; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511; Acts 2015, No. 1223, § 36.

A.C.R.C. Notes. Acts 2015, No. 1223, § 26, provided: "The operative date of the valuation manual under Arkansas Code, Title 23, Chapter 84, is the first January 1 of the year after the valuation manual is effective."

Amendments. The 2015 amendment rewrote the section.

23-84-103. Minimum standard for valuation generally.

(a) Except as provided in §§ 23-84-104, 23-84-105, and 23-84-114, the minimum standard for the valuation of all policies and contracts issued prior to the operative date of § 23-81-213(a) shall be provided by the laws in effect immediately prior to January 1, 1960.

(b) Except as otherwise provided in §§ 23-84-104, 23-84-105, and 23-84-114, the minimum standard for the valuation of all policies and contracts issued on or after the operative date of § 23-81-213(a) shall be the Insurance Commissioner's reserve valuation methods defined in §§ 23-84-106, 23-84-107, 23-84-110, and 23-84-114, three and one-half percent (3.5%) interest, or in the case of policies and contracts, other than annuity and pure endowment contracts, five and one-half percent (5.5%) interest for single premium life insurance policies and four and one-half percent (4.5%) interest for all other policies issued on and after March 18, 1977, and the following tables:

(1) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in the policies:

(A) The Commissioner's 1941 Standard Ordinary Mortality Table for policies issued prior to the operative date of § 23-81-213(b);

(B)(i) For policies issued on or after the operative date of § 23-81-213(b) and prior to the operative date of § 23-81-213(d), the Commissioner's 1958 Standard Ordinary Mortality Table.

(ii) For any category of policies issued on female risks under this subdivision (b)(1)(B), all modified net premiums and present values referred to in this chapter may be calculated according to an age not more than six (6) years younger than the actual age of the insured; or

(C) For policies issued on or after the operative date of § 23-81-213(d):

(i) The Commissioner's 1980 Standard Ordinary Mortality Table;

(ii) At the election of the insurer, for any one (1) or more specified plans of life insurance, the Commissioner's 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; or

(iii) Any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by rules promulgated by the commissioner for the use in determining the minimum standard of valuation for the policies;

(2) For industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies, the Commissioner's 1941 Standard Industrial Mortality Table for policies issued prior to the operative date of § 23-81-213(c) and, for policies issued on or after the operative date of § 23-81-213(c), the Commissioner's 1961 Standard Industrial Mortality Table or any industrial mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by rules promulgated

by the commissioner for use in determining the minimum standard of valuation for the policies;

(3) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in the policies, the 1937 Standard Annuity Mortality Table, or, at the option of the insurer, the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the commissioner;

(4) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in the policies, the Group Annuity Mortality Table for 1951, any modification of the table approved by the commissioner, or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

(5) For total and permanent disability benefits in or supplementary to ordinary policies or contracts, for policies or contracts issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit, or any tables of disablement rates and termination rates adopted after 1980 by the National Association of Insurance Commissioners that are approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for the policies and, for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either such tables, or, at the option of the insurer, the Class (3) Disability Table (1926) and, for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any table, for active lives, shall be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(6) For accidental death benefits in or supplementary to policies, for policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for the policies and, for policies issued on or after January 1, 1961, and prior to January 1, 1966, either such table, or, at the option of the insurer, the Inter-Company Double Indemnity Mortality Table and, for policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality Table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies; and

(7) For group life insurance, life insurance issued on the substandard basis, and other special benefits, such tables as may be approved by the commissioner.

History. Acts 1959, No. 148, § 92; 1961, No. 466, § 1; 1965, No. 439, § 1; 1977, No. 551, § 2; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511; Acts 2005, No. 506, § 44; 2015, No. 1223, §§ 37-39; 2019, No. 315, §§ 2733, 2734.

Amendments. The 2015 amendment substituted "provided in §§ 23-84-104, 23-

84-105, and 23-84-114" for "otherwise provided in §§ 23-84-104 and 23-84-105" in (a); added "and 23-84-114" twice in the introductory language of (b); and, in (b)(2), deleted "all" following "For" and inserted "of § 23-81-213(c)" preceding "the Commissioner's".

The 2019 amendment substituted "rules" for "regulations" in (b)(2); and substituted "rule" for "regulation" in (b)(5) and (b)(6).

23-84-104. Minimum standard for valuation — Annuity and pure endowment contracts.

(a) Except as provided in § 23-84-105, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this section and for all annuities and pure endowments purchased on or after the operative date under group annuity and pure endowment contracts shall be the Insurance Commissioner's reserve valuation methods defined in §§ 23-84-106 and 23-84-107 and the following tables and interest rates:

(1) For individual single premium immediate annuity contracts excluding any disability and accidental death benefits in the contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners and approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for the contracts, or any modification of these tables approved by the commissioner, and seven and one-half percent (7.5%) interest;

(2) For individual annuity and pure endowment contracts other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in the contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for the contracts, or any modification of these tables approved by the commissioner, and five and one-half percent (5.5%) interest for single premium deferred annuity and pure endowment contracts and four and one-half percent (4.5%) interest for all other individual annuity and pure endowment contracts; and

(3) For all annuities and pure endowments under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under the contracts, the 1971 Group Annuity Mortality Table or any group annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by rules promulgated by the commissioner for use in determining the minimum standard of valuation for the annuities and pure endowments, or any modification of these tables approved by the commissioner, and seven and one-half percent (7.5%) interest.

(b) After March 18, 1977, any insurer may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1979, which shall be the

operative date of this section for the insurer. However, an insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer makes no election, the operative date of this section for the insurer shall be January 1, 1979.

History. Acts 1959, No. 148, § 92; 1961, No. 466, § 1; 1965, No. 439, § 1; 1977, No. 551, § 2; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511; Acts 2019, No. 315, § 2735.

Amendments. The 2019 amendment substituted "rule" for "regulation" in (a)(1) and (a)(2); and substituted "rules" for "regulations" in (a)(3).

23-84-105. Minimum standard for valuation — Interest rates — Definitions.

(a) Applicability of this Section. The interest rates used in determining the minimum standard for the valuation of the following shall be the calendar year statutory valuation interest rates as defined in this chapter:

(1) All life insurance policies issued in a particular calendar year, on or after the operative date of § 23-81-213(d);

(2) All individual annuity and pure endowment contracts issued in a particular calendar year on or after the operative date of § 23-81-213(e);

(3) All annuities and pure endowments purchased in a particular calendar year on or after the operative date of § 23-81-213(e), under group annuity and pure endowment contracts; and

(4) The net increase, if any, in a particular calendar year after the operative date of § 23-81-213(e), in amounts held under guaranteed interest contracts.

(b) Calendar Year Statutory Valuation Interest Rates.

(1) The calendar year statutory valuation interest rates, I, shall be determined as follows and the results rounded to the nearer one-quarter of one percent (0.25%):

(A) For life insurance:

$$I=.03+W(R_1-.03)+\frac{W}{2}(R_2-.09);$$

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

$$I=.03+W(R-.03)$$

where R_1 is the lesser of R and .09, R_2 is the greater of R and .09, R is the reference interest rate defined in subsection (d) of this section, and W is the weighting factor defined in subsection (c) of this section;

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options valued on an

issue year basis, except as stated in subdivision (b)(1)(B) of this section, the formula for life insurance stated in subdivision (b)(1)(A) of this section shall apply to annuities and guaranteed interest contracts with guaranteed durations in excess of ten (10) years. The formula for single premium immediate annuities stated in subdivision (b)(1)(B) of this section shall apply to annuities and guaranteed interest contracts with guaranteed duration of ten (10) years or less;

(D) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in subdivision (b)(1)(B) of this section shall apply; and

(E) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in subdivision (b)(1)(B) of this section shall apply.

(2)(A) However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this subdivision (b)(2)(A) differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent (0.5%), the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year.

(B) For purposes of applying subdivision (b)(2)(A) of this section, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 by using the reference interest rate defined for 1979 and shall be determined for each subsequent calendar year regardless of the operative date of § 23-81-213(d).

(c) Weighting Factors.

(1) The weighting factors referred to in the formulas stated in subsection (b) of this section are given in the following tables:

(A) Weighting Factors for Life Insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values, or both, which are guaranteed in the original policy;

(B) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other

annuities with cash settlement options and guaranteed interest contracts with cash settlement options:

.80

(C) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in subdivision (c)(1)(B) of this section, shall be as specified in tables (i), (ii), and (iii) of this subdivision (c)(1)(C), according to the rules and definitions in tables (iv) and (v) of this subdivision (c)(1)(C):

(i) For annuities and guaranteed interest contracts valued on an issue-year basis:

Guarantee Duration (Years)	Weighting Factor for Plan Type		
	A	B	C
5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

(ii) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in table (i) of this subdivision (c)(1)(C) increased by:

Plan Type		
A	B	C
.15	.25	.05

(iii) For annuities and guaranteed interest contracts valued on an issue-year basis, other than those with no cash settlement options which do not guarantee interest on considerations received more than one (1) year after issue or purchase and for annuities and guaranteed interest contracts valued on a change-in-fund basis which do not guarantee interest rates on considerations received more than twelve (12) months beyond the valuation date, the factors shown in table (i) of this subdivision (c)(1)(C) or derived in table (ii) of this subdivision (c)(1)(C) increased by:

Plan Type		
A	B	C
.05	.05	.05

(iv) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guaranteed duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty (20) years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options,

the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence;

(v) Plan type as used in the tables in this subdivision (c)(1)(C) is defined as follows:

Plan Type A: At any time, a policyholder may withdraw funds only:

(a) With an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer;

(b) Without such an adjustment but in installments over five (5) years or more;

(c) As an immediate life annuity; or

(d) No withdrawal permitted;

Plan Type B: Before expiration of the interest rate guarantee, a policyholder may withdraw funds only:

(a) With adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer;

(b) Without such an adjustment but in installments over five (5) years or more; or

(c) No withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without such an adjustment in a single sum or installments over less than five (5) years; and

Plan Type C: A policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five (5) years either:

(a) Without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; or

(b) Subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(2)(A)(i) An insurer may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue-year basis or on a change-in-fund basis.

(ii) Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue-year basis.

(B) As used in this chapter:

(i) "Issue-year basis of valuation" means a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract; and

(ii) "Change-in-fund basis of valuation" means a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

(d) Reference Interest Rate. The reference interest rate referred to in subsection (b) of this section shall be defined as follows:

(1) For all life insurance, the lesser of the average over a period of thirty-six (36) months and the average over a period of twelve (12) months, ending June 30 of the calendar year next preceding the year of issue, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by Moody's Investors Service, Inc.;

(2) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or year of purchase of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by Moody's Investors Service, Inc.;

(3) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year-of-issue basis, except as stated in subdivision (d)(2) of this section, with guarantee duration in excess of ten (10) years, the lesser of the average over a period of thirty-six (36) months and the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by Moody's Investors Service, Inc.;

(4) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year-of-issue basis, except as stated in subdivision (d)(2) of this section, with guarantee duration of ten (10) years or less, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by Moody's Investors Service, Inc.;

(5) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by Moody's Investors Service, Inc.; and

(6) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change-in-fund basis, except as stated in subdivision (d)(2) of this section, the average over a period of twelve (12) months, ending on June 30 of the calendar year of the change in the fund, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by the Moody's Investors Service, Inc.

(e) Alternative Method for Determining Reference Interest Rates. In the event that the Monthly Average of the Composite Yield on Seasoned Corporate Bonds is no longer published by Moody's Investors Service, Inc., or in the event that the National Association of Insurance Commissioners determines that the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by Moody's Investors Service, Inc., is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of

the reference interest rate which is adopted by the National Association of Insurance Commissioners and approved by rules promulgated by the Insurance Commissioner may be substituted.

History. Acts 1959, No. 148, § 92; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511; Acts 1995, No. 624, § 1; 2019, No. 315, § 2736.

Amendments. The 2019 amendment substituted "rule" for "regulation" in (e).

23-84-106. Calculation of reserves generally.

(a) Except as otherwise provided in §§ 23-84-107 and 23-84-110, reserves according to the Insurance Commissioner's reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value at the date of valuation, of such future guaranteed benefits provided for by the policies, over the then-present value of any future modified net premiums therefor. The modified net premiums for any policy shall be a uniform percentage of the respective contract premiums for the benefits such that the present value, at the date of issue of the policy, of all modified net premiums shall be equal to the sum of the then-present value of benefits provided for by the policy and the excess of subdivision (a)(1) of this section over subdivision (a)(2) of this section, as follows:

(1) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one (1) per annum payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at an age one (1) year higher than the age at issue of the policy; and

(2) A net one-year-term premium for the benefits provided for in the first policy year.

(b)(1) However, for any life insurance policy issued on or after January 1, 1985, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for the excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than the excess premium, the reserve according to the commissioner's reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined in this section as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than the excess premium shall, except as otherwise provided in § 23-84-110, be the greater of the reserve as of the policy anniversary calculated as described in subsection (a) of this section and the reserve as of the policy anniversary calculated as described in subsection (a) of this section, but with:

(A) The value defined in subdivision (a)(1) of this section being reduced by fifteen percent (15%) of the amount of the excess first year premium;

(B) All present values of benefits and premiums being determined without reference to premiums or benefits provided by the policy after the assumed ending date; and

(C) The policy being assumed to mature on that date being considered as an endowment benefit.

(2) In making the comparison in subdivision (b)(1) of this section, the mortality and interest bases stated in §§ 23-84-104 and 23-84-105 shall be used.

(c) Reserves according to the commissioner's reserve valuation method for:

(1) Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;

(2) Group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as now or hereafter amended;

(3) Disability and accidental death benefits in all policies and contracts; and

(4) All other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts,

shall be calculated by a method consistent with the principles of this section.

History. Acts 1959, No. 148, § 92; 1961, No. 466, § 2; 1977, No. 551, § 3; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511; Acts 2015, No. 1223, § 40.

Amendments. The 2015 amendment inserted "such" preceding "that the present value" in the second sentence of the introductory language of (a).

23-84-108. Calculation of reserves — Minimum aggregate reserves for certain life insurance policies.

(a) In no event shall an insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on or after June 17, 1981, be less than the aggregate reserves calculated in accordance with the methods set forth in §§ 23-84-106, 23-84-107, 23-84-110, and 23-84-111, and the mortality tables and rates of interest used in calculating nonforfeiture benefits for the policies.

(b) In no event shall the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the appointed actuary to be necessary to render the opinion required by § 23-84-112.

History. Acts 1959, No. 148, § 92; 1977, No. 551, § 4; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511; Acts 1995, No. 1272, § 17; 2015, No. 1223, § 41.

Amendments. The 2015 amendment substituted "appointed" for "qualified" in (b).

23-84-109. Calculation of reserves — Standards of valuation.

(a) Reserves for policies and contracts issued before January 1, 1960, may be calculated, at the option of the insurer, according to any standards which produce greater aggregate reserves for all the policies and contracts than the minimum reserves required by the laws in effect immediately prior to the date.

(b) Reserves for any category of policies, contracts, or benefits as established by the Insurance Commissioner which are issued on or after January 1, 1960, may be calculated, at the option of the insurer, according to any standards which produce greater aggregate reserves for the category than those calculated according to the minimum standard provided in this chapter, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be greater than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided in the policies or contracts.

(c)(1) Any insurer which at any time shall have adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided in this chapter may adopt, with the approval of the commissioner, any lower standard of valuation, but not lower than the minimum provided in this chapter.

(2) However, for the purposes of this chapter, the holding of additional reserves previously determined by the appointed actuary to be necessary to render the opinion required by § 23-84-112 shall not be deemed to be the adoption of a higher standard of valuation.

History. Acts 1959, No. 148, § 92; 1977, No. 551, § 5; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511; Acts 1995, No. 1272, § 18; 2015, No. 1223, § 42.

Amendments. The 2015 amendment, in (a), deleted "all" following "Reserves for" and substituted "before January 1, 1960" for "prior to the applicable operative date of this chapter"; in (b), substituted "January 1, 1960" for "the applicable operative date of this chapter," "greater than" for "higher than," and "in the policies or contracts" for "therein"; and substituted "the appointed" for "a qualified" in (c)(2).

23-84-110. Calculation of reserves — Certain life insurance policies and contracts.

(a) If in any contract year the gross premium charged by a company on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon, but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for the policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually

used for the policy or contract, or the reserve calculated by the method actually used for the policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in §§ 23-84-103 and 23-84-104.

(b)(1) However, for any life insurance policy issued on or after January 1, 1985, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for the excess and which provides an endowment benefit or a cash surrender value, or a combination thereof, in an amount greater than the excess premium, the provisions of subsection (a) of this section shall be applied as if the method actually used in calculating the reserve for the policy was the method described in § 23-84-106, ignoring § 23-84-106(b).

(2) The minimum reserve at each policy anniversary of the policy shall be the greater of the minimum reserve calculated in accordance with § 23-84-106, including § 23-84-106(b), and the minimum reserve calculated in accordance with this section.

History. Acts 1959, No. 148, § 92; 1977, No. 551, § 6; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511; Acts 2015, No. 1223, § 43.

Amendments. The 2015 amendment substituted "a company" for "any life insurer" near the beginning of (a).

23-84-111. Calculation of reserves — Future premium determinations by life insurers.

(a) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on then-estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in §§ 23-84-106, 23-84-107, and 23-84-110, the reserves which are held under any such plan must be:

(1) Appropriate in relation to the benefits and the pattern of premiums for that plan; and

(2) Computed by a method which is consistent with the principles of this chapter, as determined by rules promulgated by the Insurance Commissioner.

(b) Notwithstanding any other provisions in the law of this state, any policy, contract, or certificate providing life insurance under any plan must be affirmatively approved by the commissioner before it can be marketed, issued, delivered, or used in this state.

History. Acts 1959, No. 148, § 92; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511; Acts 2019, No. 315, § 2737.

Amendments. The 2019 amendment substituted "rules" for "regulations" in (a)(2).

23-84-112. Actuarial opinion of reserves — Definition.

(a) ACTUARIAL OPINION PRIOR TO OPERATIVE DATE OF THE VALUATION MANUAL.

(1) GENERAL.

(A) Every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the Insurance Commissioner by rule are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state.

(B) By rule, the commissioner shall define the specifics of this opinion and add any other items deemed to be necessary to its scope.

(2) ACTUARIAL ANALYSIS OF RESERVES AND ASSETS SUPPORTING SUCH RESERVES.

(A) Except as exempted by or pursuant to rule, every life insurance company shall also annually include in the opinion required by subdivision (a)(1) of this section an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including, but not limited to, the benefits under and expenses associated with the policies and contracts.

(B) The commissioner may provide by rule for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinion required by this section.

(3) REQUIREMENTS FOR OPINION UNDER SUBDIVISION (a)(2) OF THIS SECTION. An opinion required by subdivision (a)(2) of this section shall be governed by the following provisions:

(A) A memorandum, in form and substance acceptable to the commissioner as specified by rule, shall be prepared to support each actuarial opinion; and

(B) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified by rule or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the rules or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the commissioner.

(4) REQUIREMENT FOR ALL OPINIONS SUBJECT TO THIS SUBSECTION. An opinion required by this subsection shall be governed by the following provisions:

(A) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1995;

(B) The opinion shall apply to all business in force, including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by rule;

(C) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the commissioner may by rule prescribe;

(D) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state;

(E) For the purposes of this section, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in such rules;

(F) Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision, or conduct with respect to the actuary's opinion;

(G) Disciplinary action by the commissioner against the company or the qualified actuary shall be defined in rules by the commissioner; and

(H)(i) Any memorandum in support of the opinion and any other material provided by the company to the commissioner in connection therewith shall be kept confidential by the commissioner and shall not be made public and shall not be subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this section or by rules promulgated under this chapter.

(ii) However, the memorandum or other material may otherwise be released by the commissioner:

(a) With the written consent of the company; or

(b) To the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material.

(iii) Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before any governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall be no longer confidential.

(b) ACTUARIAL OPINION OF RESERVES AFTER OPERATIVE DATE OF THE VALUATION MANUAL.

(1) GENERAL.

(A) A company with an outstanding policy or contract in this state that is subject to regulation by the commissioner annually shall

submit the opinion of an appointed actuary as to whether the reserves and related actuarial items held in support of the policy or contract:

(i) Are computed appropriately;

(ii) Are based on assumptions that satisfy contractual provisions;

(iii) Are consistent with prior reported amounts; and

(iv) Comply with applicable laws of this state.

(B) The valuation manual shall prescribe the content and scope of the opinion.

(2) Actuarial Analysis of Reserves and Assets Supporting Such Reserves. A company with an outstanding policy or contract in this state that is subject to rules promulgated by the commissioner, except as exempted in the valuation manual, annually shall include in the opinion required by subdivision (b)(1) of this section an opinion of the appointed actuary under subdivision (b)(1)(A) of this section as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including without limitation the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including without limitation the benefits under and expenses associated with the policies and contracts.

(3) Requirements for Opinion Under Subdivision (b)(2) of this Section. The opinion required by subdivision (b)(2) of this section shall be governed by the following provisions:

(A) A memorandum in the form and substance specified in the valuation manual and acceptable to the commissioner shall be prepared to support each actuarial opinion; and

(B) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified in the valuation manual or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

(4) Requirement for All Opinions Subject to this Subsection.

(A) An opinion governed by this subsection shall:

(i) Be in form and substance as specified in the valuation manual and acceptable to the commissioner;

(ii) Be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after the operative date of the valuation manual;

(iii) Apply to all policies and contracts subject to subdivision (b)(2) of this section, plus other actuarial liabilities as may be specified in the valuation manual; and

(iv) Be based on standards adopted from time to time by the Actuarial Standards Board or its successor and on such additional standards as may be prescribed in the valuation manual.

(B) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by the company with the public official or regulatory authority responsible for regulating insurance companies of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(C) Except in cases of fraud or willful misconduct, the appointed actuary shall not be liable for damages to any person other than the company and the commissioner for any act, error, omission, decision, or conduct with respect to the appointed actuary's opinion under this subsection.

(D) Disciplinary action by the commissioner against the company or the appointed actuary shall be prescribed by rule of the commissioner.

History. Acts 1995, No. 621, § 1; 2015, No. 1223, § 44; 2019, No. 315, §§ 2738-2740.

A.C.R.C. Notes. Acts 2015, No. 1223, § 26, provided: "The operative date of the valuation manual under Arkansas Code, Title 23, Chapter 84, is the first January 1 of the year after the valuation manual is effective."

Amendments. The 2015 amendment inserted designation (a) and the subsection (a) heading; redesignated former (a) through (d) as (a)(1) through (a)(4); added "Subject to this Subsection" in the subdivision (a)(4) heading and inserted "required by this subsection" in the introductory language of (a)(4); added present (b); and updated internal references.

The 2019 amendment substituted "rule" for "regulation" throughout the section; substituted "rules" for "regulations" in (a)(3)(B), (a)(4)(E), (a)(4)(G), and (a)(4)(H)(i); and substituted "rules promulgated" for "regulations" in (b)(2).

23-84-113. Rules.

The Insurance Commissioner shall have the authority to promulgate reasonable rules as may be appropriate to carry out the purposes and provisions of this chapter.

History. Acts 1995, No. 1272, § 19; 2019, No. 315, § 2741.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in the section heading and the text.

23-84-114. Minimum standard for accident and health insurance.

(a) The Insurance Commissioner shall promulgate rules containing the minimum standards that apply to the valuation of accident and health insurance issued on or after January 1, 1960, but before the operative date of the valuation manual.

(b) For accident and health insurance issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under § 23-84-102(b).

History. Acts 2015, No. 1223, § 45.

A.C.R.C. Notes. Acts 2015, No. 1223, § 26, provided: "The operative date of the valuation manual under Arkansas Code, Title 23, Chapter 84, is the first January 1 of the year after the valuation manual is effective."

23-84-115. Valuation of policy or contract issued on or after operative date of the valuation manual.

(a) Except as provided in this section, for a policy or contract issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under § 23-84-102(b).

(b) The valuation manual shall specify:

(1) Minimum valuation standards and definitions for policies or contracts subject to § 23-84-102(b), including without limitation:

(A) The Insurance Commissioner's reserve valuation method for life insurance contracts, other than annuity contracts, subject to § 23-84-102(b);

(B) The commissioner's annuity reserve valuation method for annuity contracts subject to § 23-84-102(b); and

(C) Minimum reserves for all other policies or contracts subject to § 23-84-102(b);

(2) Which policies or contracts or types of policies or contracts are subject to the requirements of a principle-based valuation under § 23-84-116(a) and the minimum valuation standards consistent with those requirements;

(3) For policies and contracts subject to a principle-based valuation under § 23-84-116:

(A) Requirements for the format of reports to the commissioner under § 23-84-116(b)(3), including without limitation information necessary to determine if the valuation is appropriate and in compliance with this chapter;

(B) Assumptions for risks over which the company does not have significant control or influence; and

(C) Procedures for corporate governance and oversight of the actuarial function and a process for appropriate waiver or modification of those procedures;

(4) For policies not subject to a principle-based valuation under § 23-84-116, a minimum valuation standard:

(A) That is consistent with the minimum standard of valuation before the operative date of the valuation manual; or

(B) That requires reserves to be developed that quantify the benefits and guarantees and the funding associated with the policy or contract and its risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring;

(5) Other requirements, including without limitation those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk

measurement, disclosure, certifications, reports, actuarial opinions and memorandums, and transition rules and internal controls; and

(6) The data and form of the data required under § 23-84-117, with whom the data must be submitted and, if desired, other requirements, including data analyses and reporting of data analyses.

(c) If a specific valuation requirement is not specified in the valuation manual or if in the opinion of the commissioner a specific valuation requirement in the valuation manual is not in compliance with this chapter, then the company shall comply with minimum valuation standards prescribed by the commissioner for the specific valuation requirement.

(d)(1) The commissioner may employ or contract with a qualified actuary at the expense of a company to:

(A) Perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company; or

(B) Review and opine on a company's compliance with any requirement under this chapter.

(2) The commissioner may rely upon an opinion regarding provisions contained within this chapter of a qualified actuary employed or contracted with by a public official or regulatory authority responsible for regulating insurance companies of another state, district, or territory of the United States.

(e) The commissioner may:

(1) Require a company to change any assumption or method that in the opinion of the commissioner is necessary in order to comply with the requirements of the valuation manual or this chapter;

(2) Require a company to adjust the company's reserves; and

(3) Take other disciplinary action permitted by § 23-60-108.

History. Acts 2015, No. 1223, § 45.

A.C.R.C. Notes. Acts 2015, No. 1223, § 26, provided: "The operative date of the valuation manual under Arkansas Code, Title 23, Chapter 84, is the first January 1 of the year after the valuation manual is effective."

23-84-116. Requirements of principle-based valuation.

(a) A company shall establish reserves for a policy or contract using a principle-based valuation as specified in the valuation manual that:

(1)(A) Quantifies the benefits and guarantees and the funding associated with the policy or contract and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the policy or contract.

(B) For a policy or contract with significant tail risk, the principle-based valuation shall reflect conditions appropriately adverse to quantify the tail risk;

(2) Incorporates assumptions, risk analysis methods, financial models, and management techniques that are consistent with, but not

necessarily identical to, those utilized within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods;

(3) Incorporates assumptions that are:

(A) Prescribed by the valuation manual; or

(B) For assumptions that are not prescribed by the valuation manual:

(i) Established utilizing the company's available experience to the extent it is relevant and statistically credible; and

(ii) To the extent that company data is not available, relevant, or statistically credible, established utilizing other relevant, statistically credible experience; and

(4) Provides margins for uncertainty, including adverse deviation and estimation error, such that the greater the uncertainty, the larger the margin and resulting reserve.

(b) A company using a principle-based valuation for one (1) or more policies or contracts subject to this section as specified in the valuation manual shall:

(1) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual;

(2)(A) Provide to the Insurance Commissioner and its board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation.

(B) The controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to the principle-based valuation are included in the valuation and that valuations are made in accordance with the valuation manual.

(C) The annual certification shall be based on the controls in place as of the end of the preceding calendar year; and

(3) Develop and file with the commissioner upon request a principle-based valuation report that complies with the standards prescribed in the valuation manual.

(c) A principle-based valuation may include a prescribed formulaic reserve component.

History. Acts 2015, No. 1223, § 45.

23-84-117. Experience reporting.

For a policy or contract in force on or after the operative date of the valuation manual, a company shall submit mortality, morbidity, policyholder behavior, or expense and other data as prescribed in the valuation manual.

History. Acts 2015, No. 1223, § 45.

A.C.R.C. Notes. Acts 2015, No. 1223, § 26, provided: "The operative date of the valuation manual under Arkansas Code, Title 23, Chapter 84, is the first January 1 of the year after the valuation manual is effective."

23-84-118. Confidentiality — Definition.

(a) As used in this section, "confidential information" means:

(1) A memorandum in support of an opinion submitted under § 23-84-112 and any other documents, materials, and other information, including without limitation all working papers and copies of working papers created, produced, or obtained by or disclosed to the Insurance Commissioner or any other person in connection with the memorandum;

(2)(A) Except as provided in subdivision (a)(2)(B) of this section, all documents, materials, and other information, including without limitation all working papers and copies of working papers created, produced, or obtained by or disclosed to the commissioner or any other person in the course of an examination under § 23-84-115(d).

(B) To the extent that an examination report or other material prepared in connection with an examination under § 23-61-201 et seq. is not held as private and confidential information under § 23-61-207, an examination report or other material prepared in connection with an examination made under § 23-84-115(d) is not confidential information under this section;

(3) A report, document, material, and other information developed by a company in support of or in connection with an annual certification by the company under § 23-84-116(b)(2) evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other document, material, and other information, including without limitation all working papers and copies of working papers created, produced, or obtained by or disclosed to the commissioner or any other person in connection with the report, document, material, and other information;

(4) A principle-based valuation report developed under § 23-84-116(b)(3) and any other document, material, and other information, including without limitation all working papers and copies of working papers created, produced, or obtained by or disclosed to the commissioner or any other person in connection with the report;

(5) Experience data, including a document, material, data, and other information submitted by a company under § 23-84-117, and any other document, material, data, and other information, including without limitation all working papers and copies of working papers created or produced in connection with the experience data that are created, produced, or obtained by or disclosed to the commissioner or any other person in connection with the experience data; and

(6) Experience materials, including experience data under subdivision (a)(5) of this section, and any potentially company-identifying or personally identifiable information that is provided to or obtained by the commissioner and any other documents, materials, data, and other information, including without limitation all working papers and copies of working papers created, produced, or obtained by or disclosed to the commissioner or any other person in connection with the experience materials.

(b)(1)(A) Except as provided in this section, a company's confidential information is confidential by law and privileged and shall not be subject to:

(i) The Freedom of Information Act of 1967, § 25-19-101 et seq.;

(ii) Subpoena; or

(iii) Discovery or admissible in evidence in a private civil action.

(B) However, the commissioner is authorized to use the confidential information in the furtherance of any regulatory or legal action brought against the company as a part of the commissioner's official duties.

(2) The commissioner and any other person who received confidential information while acting under the authority of the commissioner shall not be permitted or required to testify in any private civil action concerning the confidential information.

(3)(A) Except as provided in subdivision (b)(3)(B) of this section, in order to assist in the performance of the commissioner's duties, the commissioner may share confidential information:

(i) With other state, federal, and international regulatory agencies and with the National Association of Insurance Commissioners and its affiliates and subsidiaries;

(ii) In the case of confidential information specified in subdivision (a)(1) or subdivision (a)(4) of this section only, with the Actuarial Board for Counseling and Discipline or its successor upon request stating that the confidential information is required for the purpose of professional disciplinary proceedings; and

(iii) With state, federal, and international law enforcement officials.

(B) The commissioner shall not share confidential information with a recipient under subdivision (b)(3)(A)(i) or subdivision (b)(3)(A)(ii) of this section unless the recipient agrees and has the legal authority to agree to maintain the confidentiality and privileged status of the confidential information in the same manner and to the same extent as required of the commissioner.

(4) The commissioner may receive documents, materials, data, and other information, including otherwise confidential and privileged documents, materials, data, or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions, and from the Actuarial Board for Counseling and Discipline or its successor and shall maintain as confidential or privileged any document, material, data, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or other information.

(5) The commissioner may enter into agreements governing sharing and use of information consistent with this subsection.

(6) A waiver of any applicable privilege or claim of confidentiality concerning confidential information shall not occur as a result of a

disclosure of information to the commissioner under this section or as a result of sharing information authorized by this section.

(7) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any administrative, civil, or criminal proceeding in this state.

(8) This section applies to the employees, agents, consultants, and contractors of the National Association of Insurance Commissioners and a regulatory agency or law enforcement agency identified in this section.

(c) Notwithstanding subsection (b) of this section, any confidential information of a company specified in subdivision (a)(1) or subdivision (a)(4) of this section:

(1) May be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under § 23-84-112 or a principle-based valuation report developed under § 23-84-116(b)(3) based upon an action required of the appointed actuary by this chapter;

(2) May otherwise be released by the commissioner with the written consent of the company; and

(3) Is no longer confidential information protected by this section if any portion of a memorandum in support of an opinion submitted under § 23-84-112 or a principle-based valuation report developed under § 23-84-116(b)(3) is:

(A) Cited by the company in its marketing;

(B) Publicly volunteered to or before a governmental agency other than a state insurance department; or

(C) Released by the company to the news media.

History. Acts 2015, No. 1223, § 45.

23-84-119. Single-state and small company exemptions.

(a)(1) The Insurance Commissioner may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in this state from the requirements of §§ 23-84-115 — 23-84-117 if:

(A) The commissioner has issued a written exemption to the company and has not subsequently revoked the exemption in writing; and

(B) The company computes reserves using assumptions and methods used before the operative date of the valuation manual in addition to any requirements established by the commissioner.

(2) If a company is granted an exemption under subdivision (a)(1) of this section:

(A) Sections 23-84-103 — 23-84-114 apply to the company; and

(B) Any reference to § 23-84-115 found in §§ 23-84-103 — 23-84-112 and 23-84-114 do not apply to the company.

(b)(1) A company that has less than three hundred million dollars ($300,000,000) of ordinary life premiums, that is licensed and doing business in this state, and that is subject to the requirements of §§ 23-84-115 — 23-84-118 may hold reserves based on the mortality tables and interest rates defined by the valuation manual for net premium reserves using the methodology defined in §§ 23-84-106 and 23-84-108 — 23-84-111 as applicable to ordinary life insurance in lieu of the reserves required by §§ 23-84-115 — 23-84-118, if:

(A) In the event the company is a member of a group of life insurers, the group has combined ordinary life premiums of less than six hundred million dollars ($600,000,000);

(B)(i) The company reported total adjusted capital of at least four hundred fifty percent (450%) of authorized control level risk-based capital in the most recent risk-based capital report.

(ii) Upon written request from a company that does not satisfy subdivision (b)(1)(B)(i) of this section, the commissioner may exempt the company from subdivision (b)(1)(B)(i) of this section;

(C) The appointed actuary has provided an unqualified opinion on the reserves in accordance with § 23-84-112; and

(D) The company has provided a certification by a qualified actuary that any universal life policy with a secondary guarantee issued or assumed by the company after the operative date of the valuation manual meets the definition of a nonmaterial secondary guarantee universal life product as defined in the valuation manual.

(2) For purposes of subdivision (b)(1) of this section, ordinary life premiums are measured as direct premium plus reinsurance assumed from an unaffiliated company, as reported in the prior calendar year annual statement.

(3)(A) On or before July 1 each year, a domestic company that meets all of the conditions required by this subsection may file a statement with the commissioner certifying that the conditions are met for the current calendar year based on premiums and other values from the financial statements of the prior calendar year.

(B) The commissioner may reject the statement on or before September 1 of the same calendar year and require the domestic company to comply with the valuation manual requirements for life insurance reserves.

History. Acts 2015, No. 1223, § 45.

A.C.R.C. Notes. Acts 2015, No. 1223, § 26, provided: "The operative date of the valuation manual under Arkansas Code, Title 23, Chapter 84, is the first January 1 of the year after the valuation manual is effective."

CHAPTER 85

ACCIDENT AND HEALTH INSURANCE

23-85-104. Form of policy.

No policy of accident and health insurance shall be delivered or issued for delivery to any person in this state unless it otherwise complies with this code and complies with the following:

(1) The entire money and other considerations for the policy shall be expressed in the policy;

(2) The time when the insurance takes effect and terminates shall be expressed in the policy;

(3) It shall purport to insure only one (1) person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any two (2) or more eligible members of that family, including husband, wife, or any other person dependent upon the policyholder;

(4)(A) The style, arrangement, and overall appearance of the policy shall give no undue prominence to any portion of the text.

(B) In printed forms, every portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than 10-point type with a lower case unspaced alphabet length not less than one hundred twenty (120) points.

(C) The appearance of text in forms developed for electronic transmission shall comply with rules developed by the Insurance Commissioner.

(D) The text shall include all printed matter, except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions;

(5) The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in §§ 23-85-106 — 23-85-126 and 23-85-128, shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions", or "Exceptions and Reductions", except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction shall be included with the benefit provision to which it applies;

(6) Each form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page; and

(7) The policy shall contain no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part

of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risk or a short-rate table filed with the commissioner.

History. Acts 1959, No. 148, § 387; 1967, No. 418, § 1; 1969, No. 263, § 1; A.S.A. 1947, § 66-3602; Acts 2001, No. 909, § 4; 2019, No. 315, § 2742.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (4)(C).

23-85-131. Age limit — Exception.

(a) If any policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective and if the date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after the date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective or would have ceased prior to the acceptance of the premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

(b)(1) In any accident and health insurance contract that contains a provision whereby coverage of a dependent in a family group terminates at a specified age, there shall also be a provision that coverage of an unmarried dependent who is incapable of sustaining employment by reason of intellectual and developmental disability or physical disability, who became so incapacitated prior to the attainment of nineteen (19) years of age, and who is chiefly dependent upon the policyholder for support and maintenance shall not terminate, but coverage shall continue so long as the contract remains in force and so long as the dependent remains in such condition.

(2) At the request and expense of the insurer, proof of the incapacity or dependency must be furnished to the insurer by the policyholder, except in no event shall this requirement preclude eligible dependents under this section and §§ 23-85-104, 23-86-102, and 23-86-108, regardless of age.

(3) If the incapacity or dependency is thereafter removed or terminated, the policyholder shall so notify the insurer.

History. Acts 1959, No. 148, § 417; 1967, No. 418, § 2; 1969, No. 263, § 2; 1975, No. 404, § 1; 1975, No. 649, §§ 1, 8; 1983, No. 522, § 47; A.S.A. 1947, §§ 66-3632, 66-3632.1; Acts 1997, No. 208, § 26; 2001, No. 909, § 7; 2019, No. 1035, § 51.

A.C.R.C. Notes. Acts 1997, No. 208, § 1, as reenacted by Acts 2017, No. 255, § 1, provided: "Legislative intent and purpose. The General Assembly hereby acknowledges that many of the laws relating to individuals with disabilities are antiquated, functionally outmoded, derogatory, and ambiguous or are inconsistent with more recently enacted provisions of the law. Consequently, it is the intent of the General Assembly and the purpose of this act to clarify the relevant chapters of Titles 1, 6, 9, 13, 14, 16, 17, 20, 22, 23, and 27 of the Arkansas Code of 1987 Anno-

tated."

Amendments. The 2019 amendment substituted "intellectual and developmental disability" for "mental retardation" in (b)(1).

23-85-132. Reduction of benefits due to other insurance contracts prohibited.

(a) No contract of individual accident and health insurance or health coverage sold, delivered, or issued for delivery or offered for sale in this state by an insurer, hospital and medical service corporation, or health maintenance organization, directly or indirectly providing indemnity services, healthcare services, or cash to an individual as a result of hospitalization, medical or surgical treatment, or dental care shall contain a provision reducing the benefit that would otherwise be payable to the individual in the absence of other insurance or health coverage if the reduction of benefits is due solely to the existence of one (1) or more additional contracts providing benefits to that individual unless the reduction complies with coordination of benefit rules adopted by the Insurance Commissioner.

(b) No contract of individual accident and health insurance sold, delivered, or issued for delivery or offered for sale in this state providing disability income coverage shall contain any provision for the denial or reduction of benefits because of the existence of other insurance, except as provided in § 23-85-122 or any coverages approved by the commissioner pursuant thereto and except that the benefits may be reduced to offset disability income benefits payable under the Social Security Act.

(c) The commissioner may issue rules to implement this section, including, but not limited to, rules as to the amount of reductions and the nature and timing of proofs of eligibility for Social Security benefits.

History. Acts 1971, No. 346, §§ 1, 2; 1981, No. 809, §§ 15, 16; A.S.A. 1947, §§ 66-3634, 66-3635; Acts 1999, No. 624, § 1; 2001, No. 909, § 8; 2019, No. 315, § 2743.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (a); and in (c), deleted "and regulations" following the first occurrence of "rules", and substituted the second occurrence of "rules" for "regulations".

23-85-140. Nonparticipation in maintenance of licensure or maintenance of certification — Insurer prohibited from denying reimbursement or discriminating in reimbursement levels — Definitions.

(a) As used in this section:

(1) "Maintenance of certification" means any process requiring periodic recertification examinations or other activities to maintain specialty medical certification; and

(2) "Specialty medical board certification" means a certification by a board that:

(A) Specializes in one (1) particular area of medicine; and

(B) Typically requires examinations that are in addition to the requirements of the Arkansas State Medical Board to practice medicine.

(b) An insurer shall not:

(1) Deny reimbursement to or prevent a physician from participating in any provider network based solely on a decision of the physician not to participate in any form of maintenance of certification; or

(2) Discriminate with respect to reimbursement levels based solely on a decision of the physician not to participate in any form of maintenance of certification.

History. Acts 2019, No. 804, § 3.

CHAPTER 86

GROUP AND BLANKET ACCIDENT AND HEALTH INSURANCE

SUBCHAPTER.

Subchapter 1 — General Provisions

SECTION.

Effective Dates. Acts 2015, No. 887, § 6: Apr. 1, 2015. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that Arkansas is experiencing a healthcare professional maldistribution resulting in medically underserved areas throughout the state; that allowing healthcare professionals to provided healthcare services through telemedicine will ease the burden on medically underserved areas; and that this act is immediately necessary because the citizens of Arkansas and the healthcare professionals of Arkansas need immediate direction about the law regarding healthcare services provided through telemedicine. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by

the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

23-86-102. Blanket accident and health insurance — Required provisions.

(a) Any insurer authorized to write accident and health insurance in this state shall have the power to issue blanket accident and health insurance.

(b) No blanket policy may be issued or delivered in this state unless a copy of the form shall have been filed in accordance with § 23-79-109.

(c) Every blanket policy shall contain provisions that in the opinion of the Insurance Commissioner are at least as favorable to the policyholder and the individual insured as the following:

(1) A provision that the policy and the application shall constitute the entire contract between the parties and that all statements made by the policyholder, in the absence of fraud, shall be deemed representations and not warranties, and that no such statements shall be used in defense to a claim under the policy, unless it is contained in a written application;

(2)(A) A provision that written notice of sickness or of injury must be given to the insurer within twenty (20) days after the date when such sickness or injury occurred.

(B) Failure to give notice within the time shall not invalidate or reduce any claim, if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible;

(3)(A) A provision that the insurer will furnish to the policyholder such forms as are usually furnished by it for filing proof of loss.

(B) If the forms are not furnished before the expiration of fifteen (15) days after the giving of the notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made;

(4)(A) A provision that in the case of claim for loss of time for disability, written proof of the loss must be furnished to the insurer within thirty (30) days after the commencement of the period for which the insurer is liable, and the subsequent written proofs of the continuance of the disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of loss.

(B) Failure to furnish proof within the time shall not invalidate or reduce any claim, if it shall be shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible;

(5) A provision that all benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of due written proof of the loss, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not later than at the expiration of each period of thirty (30) days during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of the period will be paid immediately upon receipt of the proof;

(6) A provision that the insurer, at its own expense, shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law;

(7) A provision that no action at law or in equity shall be brought to recover under the policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished; and

(8)(A) In any contract that contains a provision whereby coverage of a dependent in a family group terminates at a specified age, there shall also be a provision that coverage of an unmarried dependent who is incapable of sustaining employment by reason of intellectual and developmental disability or physical disability, who became so incapacitated prior to the attainment of nineteen (19) years of age, and who is chiefly dependent upon the employee for support and maintenance shall not terminate, but coverage shall continue so long as the contract remains in force and so long as the dependent remains in such condition.

(B) At the request and expense of the insurer, proof of the incapacity or dependency must be furnished to the insurer by the policyholder. In no event shall this requirement preclude eligible dependents under Acts 1975, No. 649, § 5, as amended, regardless of age.

(C) If the incapacity or dependency is thereafter removed or terminated, the policyholder shall so notify the insurer.

History. Acts 1959, No. 148, § 423; 1967, No. 418, § 4; 1969, No. 263, § 4; 1975, No. 404, § 3; 1975, No. 649, §§ 3, 8; 1983, No. 522, §§ 33, 48; A.S.A. 1947, § 66-3705; Acts 1997, No. 208, § 27; 2001, No. 1063, § 3; 2019, No. 1035, § 52.

A.C.R.C. Notes. Acts 1997, No. 208, § 1, as reenacted by Acts 2017, No. 255, § 1, provided: "Legislative intent and purpose. The General Assembly hereby acknowledges that many of the laws relating to individuals with disabilities are antiquated, functionally outmoded, derogatory, and ambiguous or are inconsistent with more recently enacted provisions of the law. Consequently, it is the intent of the General Assembly and the purpose of this act to clarify the relevant chapters of Titles 1, 6, 9, 13, 14, 16, 17, 20, 22, 23, and 27 of the Arkansas Code of 1987 Annotated."

Amendments. The 2019 amendment substituted "intellectual and developmental disability" for "mental retardation" in (c)(8)(A).

23-86-108. Group accident and health insurance — Required provisions.

Each group accident and health insurance policy shall contain in substance the following provisions:

(1) A provision that, in the absence of fraud, all statements made by applicants or the policyholder or by an insured person shall be deemed representations and not warranties and that no statement made for the purpose of effecting insurance shall void the insurance or reduce benefits unless contained in a written instrument signed by the policyholder of the insured person, a copy of which has been furnished to the policyholder or to the person or his or her beneficiary;

(2)(A) A provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of the employee or member and to whom benefits under the policy are payable.

(B) If dependents are included in the coverage, only one (1) certificate need be issued for each family unit;

(3) A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy;

(4)(A) In any contract that contains a provision whereby coverage of a dependent in a family group terminates at a specified age, there shall also be a provision that coverage of an unmarried dependent who is incapable of sustaining employment by reason of intellectual and developmental disability or physical disability, who became so incapacitated prior to the attainment of nineteen (19) years of age and who is chiefly dependent upon the employee for support and maintenance, shall not terminate, but coverage shall continue so long as the coverage of the employee or member remains in force and so long as the dependent remains in such condition.

(B) At the request and expense of the insurer, proof of the incapacity or dependency must be furnished to the insurer by the policyholder, except in no event shall this requirement preclude eligible dependents under Acts 1975, No. 649, § 5, as amended, regardless of age.

(C) If the incapacity or dependency is thereafter removed or terminated, the policyholder shall so notify the insurer;

(5)(A) No policy or contract of group accident and health insurance, including contracts issued by hospital and medical service corporations, that provides coverage for any of the following services when delivered on an inpatient basis shall hereafter be sold, delivered, or issued for delivery or offered for sale in this state unless the identical coverage for such services is provided when delivered on an outpatient basis:

(i) Laboratory and pathological tests;

(ii) X-rays;

(iii) Chemotherapy;

(iv) Radiation treatment; and

(v) Renal dialysis.

(B) However, the coverage required by subdivision (5)(A) of this section shall not be required when any policyholder or contract holder shall reject the coverage in writing.

(C) The definition of the services referred to in this subdivision (5) shall be the same as found in § 23-85-133.

(D) All existing group contracts, including existing group contracts issued by hospital and medical service corporations, shall conform to the provisions of this subdivision (5) upon the first anniversary of the issue date, after March 12, 1981;

(6) A provision that:

(A) All benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of written proof of such loss;

(B) Subject to proof of loss, all accrued benefits payable under the policy for loss of time will be paid not later than at the expiration of each period of thirty (30) days during the continuance of the period for which the insurer is liable; and

(C) Any balance remaining unpaid at the termination of that period will be paid immediately upon receipt of due proof; and

(7)(A) Every insurer, hospital or medical service corporation, fraternal benefit society, self-funded healthcare plan, or health maintenance organization providing replacement coverage, with respect to group accident and health benefits within a period of sixty (60) days from the date of discontinuance of a prior plan, shall immediately cover all employees and dependents:

(i) If each employee or dependent was validly covered under the previous plan at the date of the discontinuance;

(ii) If each employee or dependent is a member of the class of individuals eligible for coverage under the succeeding carrier's plan, regardless of any of the plan's limitations or exclusions relating to "actively at work" or hospital confinement; and

(iii) Only if the group accident and health benefits were provided to a group consisting of more than fifteen (15) members.

(B) The succeeding carrier shall be entitled to deduct from its benefits any benefits payable by the previous carrier pursuant to an extension of benefits provision.

(C) No provision in a succeeding carrier's plan of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's plan shall be applied with respect to those employees and dependents validly insured under the previous carrier's policy on the date of discontinuance if benefits for the condition would have been payable under the previous carrier's plan.

(D) The provisions of this section shall apply upon the issuance of an insurance policy or healthcare plan:

(i) To a group whose benefits had previously been self-insured;

(ii) To a self-insurer providing coverage to a group that had been previously covered by an insurer; and

(iii) To a group that had previously been covered by an insurer.

History. Acts 1959, No. 148, § 420; 1967, No. 418, § 3; 1969, No. 263, § 3; 1975, No. 404, §§ 2, 8; 1975, No. 649, §§ 2, 8; 1981, No. 810, § 1; 1983, No. 522, §§ 31, 32; A.S.A. 1947, § 66-3702; Acts 1987, No. 456, § 17; 1987, No. 478, § 1; 1997, No. 208, § 28; 2001, No. 1063, § 8; 2019, No. 1035, § 53.

A.C.R.C. Notes. Acts 1997, No. 208, § 1, as reenacted by Acts 2017, No. 255, § 1, provided: "Legislative intent and purpose. The General Assembly hereby acknowledges that many of the laws relating to individuals with disabilities are antiquated, functionally outmoded, derogatory, and ambiguous or are inconsistent with more recently enacted provisions of the law. Consequently, it is the intent of the General Assembly and the purpose of this act to clarify the relevant chapters of Titles 1, 6, 9, 13, 14, 16, 17, 20, 22, 23, and 27 of the Arkansas Code of 1987 Annotated."

Amendments. The 2019 amendment substituted "intellectual and developmental disability" for "mental retardation" in (4)(A).

23-86-110. Group accident and health insurance — Administration of benefits.

(a)(1) All group accident and health insurance carriers including hospital and medical service corporations shall be subject to the "primary" and "secondary" carrier rules promulgated by the Insurance Commissioner.

(2) The secondary carrier shall administer benefits on a timely basis.

(b) This section applies to group contracts of accident and health insurance sold, delivered, or issued for delivery, renewed, or offered for sale in this state.

History. Acts 1975, No. 900, §§ 2, 3; 1981, No. 702, § 2; A.S.A. 1947, §§ 66-3710, 66-3711; Acts 2001, No. 1063, § 10; 2011, No. 760, § 15; 2019, No. 315, § 2744.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (a)(1).

23-86-111. Group accident and health insurance — Payment of benefits when other like insurance exists.

(a)(1) No contract of group accident and health insurance coverage sold, delivered or issued for delivery, renewed, or offered for sale in this state by an insurer, hospital and medical service corporation, or health maintenance organization, directly or indirectly providing indemnity, services, healthcare services, or cash to an individual as a result of hospitalization, medical or surgical treatment, or dental care, shall contain any provision for the denial or reduction of benefits because of the existence of other like insurance except to the extent that the aggregate benefits with respect to the covered medical expenses incurred under the contract and all other like insurance with other insurers, hospital and medical service corporations, or health maintenance organizations exceed all covered medical expenses incurred.

(2) The term "other like insurance" may include group accident and health insurance or blanket accident and health insurance or group coverage provided by health maintenance organizations, hospital and medical service corporations, government insurance plans, except Medicaid, union welfare plans, employer or employee benefit organizations, or workers' compensation insurance or no-fault automobile coverage provided for or required by any statute.

(b)(1) No group accident and health insurance policy providing disability income coverage sold, delivered or issued for delivery, renewed, or offered for sale in this state shall provide for reduction in the amount of the disability benefits payable to the insured to the extent of and because of the existence of other such coverage unless the policy provides a minimum amount payable, regardless of the reduction, of fifty dollars ($50.00) per month.

(2) "Other such coverage" for which a reduction may be effected includes:

(A) Governmental programs such as Social Security, the Arkansas Public Employees' Retirement System, the state workers' compensation system, and all other government-sponsored, mandatory plans or programs that provide for disability benefit coverage;

(B) Disability or pension income coverages as established by the Insurance Commissioner through implementing rules; and

(C) Such other programs, coverages, or permissible reductions as the commissioner may establish through rules.

(3) The amount of any such reduction shall not be increased with any increase in the level of Social Security benefits payable that becomes effective after a claim commences.

(4) The commissioner may also issue rules to implement this section and § 23-86-110, including, but not limited to, the nature and timing of proofs of eligibility for Social Security benefits.

(c) This section shall be applicable to all group contracts of accident and health insurance sold, delivered or issued for delivery, renewed, or offered for sale in this state, except group contracts for employees whose employer pays one hundred percent (100%) of the premiums.

History. Acts 1975, No. 900, §§ 1, 2; 1979, No. 806, § 1; 1981, No. 702, §§ 1, 2; A.S.A. 1947, §§ 66-3709, 66-3710; Acts 1999, No. 624, § 2; 2001, No. 1063, § 11; 2019, No. 315, § 2745.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (b)(2)(B), (b)(2)(C), and (b)(4).

23-86-113. Minimum benefits for mental illness in group accident and health insurance policies or subscriber's contracts — Definition.

(a) Unless refused in writing, every group accident and health insurance policy or group contract of hospital and medical service corporations issued or renewed after July 1, 1983, providing hospitalization or medical benefits to Arkansas residents for conditions arising

from mental illness shall provide the following minimum benefits on and after July 1, 1983:

(1) In the case of benefits based upon confinement as an inpatient in a hospital, psychiatric hospital, or outpatient psychiatric center licensed by the Department of Health or a community mental health center certified by the Division of Aging, Adult, and Behavioral Health Services of the Department of Human Services, the benefits shall be as defined in subsection (b) of this section;

(2)(A) In the case of benefits provided for partial hospitalization in a hospital, psychiatric hospital, or outpatient psychiatric center licensed by the department or a community mental health center certified by the division as defined in subsection (b) of this section.

(B) For the purpose of this section, "partial hospitalization" means continuous treatment for at least four (4) hours, but not more than sixteen (16) hours in any twenty-four-hour period; and

(3) In the case of outpatient benefits, the benefits shall cover services furnished by:

(A) A hospital, a psychiatric hospital, or an outpatient psychiatric center licensed by the department;

(B) A physician licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.;

(C) A psychologist licensed under § 17-97-201 et seq.; or

(D) A community mental health center or other mental health clinic certified by the division to furnish mental health services as defined in subsection (b) of this section.

(b) The insurer or hospital and medical service corporation may establish a copayment requirement for mental illness benefits paid for inpatient, partial hospitalization, or outpatient care described in subsection (a) of this section, which may or may not differ from the copayment requirements for any other condition or illness, except that copayment requirements for mental illness shall not exceed a twenty percent (20%) copayment requirement.

(c)(1) For accident and health insurance sold to employers of fifty (50) or fewer employees, the insurer or hospital and medical service corporation shall not impose limits on benefits under subsection (a) of this section with regard to deductible amounts, lifetime maximum payments, payments per outpatient visit, or payments per day of partial hospitalization which differ from benefits for any other condition or illness, provided that the insurer or hospital and medical service corporation may impose an annual maximum benefit payable, which shall not be less than seven thousand five hundred dollars ($7,500) per calendar year.

(2) For accident and health insurance sold to employers of fifty-one (51) or more employees, the insurer or hospital and medical service corporation shall not impose limits on benefits under subsection (a) of this section with regard to deductible amounts, lifetime maximum payments, payments per outpatient visit, or payments per day of partial hospitalization which differ from benefits for any other condi-

tion or illness, provided that the insurer or hospital and medical service corporation may impose an annual maximum of eight (8) inpatient or partial hospitalization days together with forty (40) outpatient visits.

(d) No person shall disclose mental health history, diagnosis, or treatment services information received in an initial application for coverage or subsequent claims for benefits to any person, group, organization, or governmental agency without written consent of the insured, except for purposes of:

(1) Obtaining professional review and judgments of quality and appropriateness of treatment rendered;

(2) Litigation proceedings involving the insured and when ordered by a court;

(3) Reinsurance, when required;

(4) Applying over-insurance provisions or for purposes of claiming benefits for services on behalf of the insured; or

(5) Underwriting applications for insurance coverage.

(e) Nothing in this section shall be construed to prohibit an insurer, a hospital and medical service corporation, a healthcare plan, a health maintenance organization, or other person providing accident and health insurance or medical benefits to Arkansas residents from issuing or continuing to issue an accident and health insurance benefit plan, policy, or contract that provides benefits greater than the minimum benefits required to be made available under this section or from issuing any plans, policies, or contracts that provide benefits that are generally more favorable to the insured than those required to be made available under this section.

(f) The requirements of this section with respect to a group or blanket accident and health insurance benefit plan, policy, or subscriber contract shall be satisfied, if the coverage specified is made available to the master policyholder of the plan, policy, or contract.

(g)(1)(A) Every insurer or hospital and medical service corporation that issues a group accident and health insurance policy, contract, or agreement in this state that provides for mental health coverage shall offer coverage for the payment of services rendered by licensed professional counselors.

(B) The offer shall be made either at the time of application for, or upon the first renewal of, the policy, contract, or agreement after April 1, 1995.

(C) If the offer is accepted, the amount paid for services provided by licensed professional counselors shall be subject to the same limitations as set forth in the policy for mental health coverage.

(2) Nothing in this subsection shall be deemed to expand the scope of the practice of licensed professional counselors currently licensed by the Arkansas Board of Examiners in Counseling and possessing the qualifications set forth in § 17-27-301 et seq., or other applicable laws.

History. Acts 1983, No. 326, §§ 1-5; 1985, No. 236, § 1; A.S.A. 1947, §§ 66-

3716 — 66-3720; Acts 1995, No. 1272, § 21; 2001, No. 1063, § 13; 2013, No. 980, § 17; 2017, No. 913, § 119.

Amendments. The 2017 amendment substituted "Division of Aging, Adult, and Behavioral Health Services" for "Division of Behavioral Health Services" in (a)(1).

23-86-122. Prior approval process for experimental and investigational surgical products and medical devices — Definition.

(a) As used in this section:

(1) "Health carrier" means a:

(A) Health maintenance organization;

(B) Hospital medical service corporation; and

(C) Disability insurance company;

(2) "Health carrier" includes a:

(A) Self-insured governmental or church plan; and

(B) Third-party administrator that administers or adjusts disability benefits for a disability insurer, hospital medical service corporation, health maintenance organization, self-insured governmental plan, or self-insured church plan; and

(3) "Health carrier" does not include:

(A) An automobile insurer paying medical or hospital benefits under § 23-89-202(1) or a self-insured employer health benefits plan; or

(B) A person, company, or organization licensed or registered to issue or that issues an insurance policy or insurance contract in this state as described in §§ 23-62-102 and 23-62-104 — 23-62-107 providing medical or hospital benefits for accidental injury or disability.

(b) A health carrier that excludes or denies coverage for a specific surgical product or medical device approved for marketing by the United States Food and Drug Administration as experimental or investigational, or both, shall develop a process by which a surgeon, before utilizing the surgical product or medical device, may present medical evidence to obtain a review for the individual patient for coverage of the surgical product or medical device.

History. Acts 2013, No. 464, § 1; 2015, No. 1164, § 6.

Amendments. The 2015 amendment added "As used in this section" at the beginning of (a); in (a)(1), inserted the (A) through (C) designations; inserted the (A) and (B) designations in (a)(2); and substituted "surgical product or medical device" for "device or treatment" following "utilizing the" in (b).

23-86-123. Prior authorization by physician — Definitions.

(a) As used in this section:

(1) "Prior authorization" means the process by which a health carrier determines the medical necessity or eligibility for coverage of a healthcare service before a covered person receives the healthcare service in order to provide coverage and reimbursement for the healthcare service; and

(2) "Telemedicine" means the same as defined in § 23-79-1601.

(b) When conducting prior authorization, whether for healthcare services provided through telemedicine or provided in person, a physician who possesses a current and unrestricted license to practice medicine in the State of Arkansas shall make all adverse determinations for healthcare services, medications, or equipment prescribed by a physician.

History. Acts 2015, No. 887, § 5; 2017, No. 203, § 5.

A.C.R.C. Notes. Acts 2015, No. 887, § 1, provided: "Title. This act shall be known and may be cited as the 'Telemedicine Act'."

Acts 2015, No. 887, § 2, provided: "Legislative findings. The General Assembly finds and declares that:

"(1) The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine;

"(2) Geography, weather, availability of specialists, transportation, and other factors can create barriers to accessing appropriate health care, and a way to provide, ensure, or enhance access to health care, given these barriers, is through the appropriate use of technology to allow healthcare consumers access to qualified healthcare professionals; and

"(3) There is a need in this state to embrace efforts that will encourage:

"(A) Health insurers and healthcare professionals to support the use of telemedicine; and

"(B) All state agencies to evaluate and amend their policies and rules to remove regulatory barriers prohibiting the use of telemedicine."

Amendments. The 2017 amendment added "— Definitions" to the section heading; rewrote (a)(2); and, at the end of (b), added "for healthcare services, medications, or equipment prescribed by a physician".

Subchapter 3 — Arkansas Health Insurance Portability and Accountability Act of 1997

23-86-303. Definitions.

As used in this subchapter:

(1) "Affiliation period" means a period that, under the terms of the coverage offered by the health maintenance organization, must expire before the coverage becomes effective;

(2) "Bona fide association" means, with respect to health insurance coverage offered in Arkansas, an association that:

(A) Has been actively in existence for at least five (5) years;

(B) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(C) Does not condition membership in the association on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee;

(D) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member;

(E) Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(F) Meets the additional requirements that may be imposed under Arkansas law;

(3) "Church plan" has the meaning given the term under section 3(33) of the Employee Retirement Income Security Act of 1974 (ERISA);

(4) "COBRA continuation provision" means any of the following:

(A) Part 6 of Subtitle B of Title 1 of the Employee Retirement Income Security Act of 1974, other than section 609 of the act;

(B) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of the section insofar as it relates to pediatric vaccines;

(C) Title XXII of the Public Health Service Act;

(5) "Commissioner" means the Insurance Commissioner;

(6) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(A) A group health plan;

(B) Health insurance coverage;

(C) Part A or Part B of Title XVIII of the Social Security Act;

(D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

(E) United States Code Title 10, Chapter 55;

(F) A medical care program of the United States Indian Health Service or of a tribal organization;

(G) A state health benefits risk pool;

(H) A health plan offered under United States Code Title 5, Chapter 89;

(I) A public health plan as defined in regulations;

(J) A health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. § 2504(e). The term does not include coverage consisting solely of coverage of excepted benefits as defined in § 23-86-310;

(7) "Department" means the State Insurance Department unless the context requires otherwise;

(8) "Eligible individual" means, with respect to a health insurance issuer that offers health insurance coverage to a small employer in connection with a group health plan in the small-group market, such an individual in relation to the employer as shall be determined:

(A) In accordance with the terms of the group health plan;

(B) As provided by the issuer under rules of the issuer that are uniformly applicable in Arkansas to small employers in the small-group market; and

(C) In accordance with all applicable Arkansas law governing the issuer and the small-group market;

(9)(A) "Employee" has the meaning given the term under section 3(6) of the Employee Retirement Income Security Act of 1974.

(B) To the extent not in conflict with the Employee Retirement Income Security Act of 1974, the term "employee" also means a person who is employed by an employer for thirty (30) or more hours a week and includes an employee who is employed by a client of a professional employer organization for thirty (30) or more hours a week under a professional employer organization arrangement as governed under the Arkansas Professional Employer Organization Recognition and Licensing Act, § 23-92-401 et seq.;

(10) "Employer" has the meaning given the term under section 3(5) of the Employee Retirement Income Security Act of 1974, except that the term shall include only employers of two (2) or more employees;

(11) "Employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries;

(12) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of coverage of the individual in the group health plan or, if earlier, the first day of the waiting period for the coverage;

(13) "Federal governmental plan" means a governmental plan established or maintained for its employees by the United States Government or by any agency or instrumentality of the government;

(14) "Governmental plan" has the meaning given the term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan;

(15) "Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with the group health plan;

(16) "Group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care as defined in this section and including items and services paid for as medical care, to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise;

(17) "Group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer;

(18) "Health insurance coverage" means benefits consisting of medical care, provided directly, through insurance or reimbursement or otherwise and including items and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer;

(19) "Health insurance issuer" means an insurance company, insurance service, or insurance organization including a health maintenance

organization as defined in this section that is licensed to engage in the business of insurance in a state and that is subject to Arkansas law that regulates insurance. The term does not include a group health plan;

(20) "Health maintenance organization" means:

(A) A federally qualified health maintenance organization as defined in section 1301(a) of the Public Health Service Act, 42 U.S.C. § 300e(a);

(B) An organization recognized under state law as a health maintenance organization; or

(C) A similar organization regulated under state law for solvency in the same manner and to the same extent as a health maintenance organization;

(21) "Health status-related factor" means any of the factors described in § 23-86-306(a)(1);

(22) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan;

(23) "Large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one (51) employees on business days during the preceding calendar year and who employs at least two (2) employees on the first day of the plan year;

(24) "Large-group market" means the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan maintained by a large employer;

(25) "Late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the group health plan other than during:

(A) The first period in which the individual is eligible to enroll under the group health plan; or

(B) A special enrollment period under § 23-86-304(f);

(26) "Medical care" means amounts paid for or services provided for:

(A) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(B) Amounts paid for transportation primarily for and essential to medical care referred to in subdivision (26)(A) of this section; and

(C) Amounts paid for insurance covering medical care referred to in subdivisions (26)(A) and (B) of this section;

(27) "Network plan" means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care are provided, in whole or in part, through a defined set of providers under contract with the issuer;

(28) "Nonfederal governmental plan" means a governmental plan that is not a federal governmental plan;

(29) "Participant" has the meaning given the term under section 3(7) of the Employee Retirement Income Security Act of 1974;

(30) "Placement", or being "placed", for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by the person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child's placement with the person terminates upon the termination of the legal obligation;

(31) "Plan sponsor" has the meaning given the term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974;

(32) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date;

(33) "Rules" means rules promulgated by the Insurance Commissioner unless the context requires otherwise;

(34) "Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two (2) but not more than fifty (50) employees on business days during the preceding calendar year and who employs at least two (2) employees on the first day of the plan year;

(35) "Small-group market" means the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan maintained by a small employer;

(36) "State" means each of the several states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands;

(37)(A) "State law" includes all laws, decisions, rules, regulations, or other state action having the effect of law, of any state.

(B) A law of the United States applicable only to the District of Columbia shall be treated as a state law rather than a law of the United States; and

(38) "Waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the group health plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the group health plan.

History. Acts 1997, No. 997, § 1; 2003, No. 1750, § 8[7]; 2019, No. 315, § 2746.

Amendments. The 2019 amendment substituted "Rules" for "Regulations" and deleted "and regulations" following "rules" in (33).

23-86-304. Increased portability through limitation on preexisting conditions exclusions.

(a) Limitation on Preexisting Condition Exclusion Period — Crediting for Periods of Previous Coverage. Subject to subsection (d) of this section, a group health plan and a health insurance issuer offering

group health insurance coverage may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(1) The preexisting condition exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;

(2) The preexisting condition exclusion extends for a period of not more than twelve (12) months, or eighteen (18) months in the case of a late enrollee, after the enrollment date; and

(3) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, as defined in subdivision (c)(1) of this section, applicable to the participant or beneficiary as of the enrollment date.

(b) Treatment of Genetic Information. Genetic information shall not be treated as a condition described in subdivision (a)(1) of this section in the absence of a diagnosis of the condition related to that information.

(c) Creditable Coverage — Rules Relating to Crediting Previous Coverage.

(1) Not Counting Periods Before Significant Breaks in Coverage.

(A) In General. A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such a period and before the enrollment date, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage.

(B) Waiting Period Not Treated as a Break in Coverage. For purposes of subdivisions (c)(1)(A) and (d)(4) of this section, any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage or is in an affiliation period as defined in § 23-86-303(1) shall not be taken into account in determining the continuous period under subdivision (c)(1)(A) of this section.

(2) Method of Crediting Coverage.

(A) Standard Method. Except as otherwise provided under subdivision (c)(2)(B) of this section, for purposes of applying subdivision (a)(3) of this section, a group health plan and a health insurance issuer offering group health insurance coverage shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(B) Election of Alternative Method.

(i) A group health plan or a health insurance issuer offering group health insurance coverage may elect to apply subdivision (a)(3) of this section based on coverage of benefits within each of several classes or categories of benefits specified in rules rather than as provided under subdivision (c)(2)(A) of this section.

(ii) The election shall be made on a uniform basis for all participants and beneficiaries.

(iii) Under the election, a group health plan or health insurance issuer shall count a period of creditable coverage with respect to any

class or category of benefits if any level of benefits is covered within the class or category.

(C) Group Health Plan Notice. In the case of an election with respect to a group health plan under subdivision (c)(2)(B) of this section, whether or not health insurance coverage is provided in connection with such a group health plan, the group health plan shall:

(i) Prominently state in any disclosure statements concerning the group health plan, and state to each enrollee at the time of enrollment under the group health plan, that the group health plan has made such an election; and

(ii) Include in such statements a description of the effect of this election.

(D) Health Insurance Issuer Notice. In the case of an election under subdivision (c)(2)(B) of this section with respect to health insurance coverage offered by a health insurance issuer in the small or large group market, the health insurance issuer:

(i) Shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurance issuer has made such an election; and

(ii) Shall include in such statements a description of the effect of such an election.

(3) Establishment of Period. Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) of this section or in such other manner as may be specified in regulations.

(d) Exceptions.

(1) Preexisting Condition Exclusion Not Applicable to Certain Newborns. Subject to subdivision (d)(4) of this section, a group health plan and a health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage.

(2) Preexisting Condition Exclusion Not Applicable to Certain Adopted Children.

(A) Subject to subdivision (d)(4) of this section, a group health plan and a health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen (18) years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage.

(B) Subdivision (d)(2)(A) of this section shall not apply to coverage before the date of the adoption or placement for adoption.

(3) Preexisting Condition Exclusion Not Applicable to Pregnancy. A group health plan and a health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if Break in Coverage. Subdivisions (d)(1) and (2) of this section shall no longer apply to an individual after the end of the first sixty-three-day period during all of which the individual was not covered under any creditable coverage.

(e) Certifications and Disclosure of Coverage.

(1) Requirement for Certification of Period of Creditable Coverage.

(A) In General. A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification described in subdivision (e)(1)(B) of this section:

(i) At the time an individual ceases to be covered under the group health plan or otherwise becomes covered under a COBRA continuation provision;

(ii) In the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such a provision; and

(iii)*(a)* At the request on behalf of an individual made not later than twenty-four (24) months after the date of cessation of the coverage described in subdivision (e)(1)(A)(i) or subdivision (e)(1)(A)(ii) of this section, whichever is later.

(b) The certification under subdivision (e)(1)(A)(i) of this section may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(B) Certification. The certification described in subdivision (e)(1)(A) of this section is a written certification of:

(i) The period of creditable coverage of the individual under such a group health plan and the coverage, if any, under the COBRA continuation provision; and

(ii) The waiting period, if any, and affiliation period, if applicable, imposed with respect to the individual for any coverage under such a group health plan.

(C) Issuer Compliance. To the extent that medical care under a group health plan consists of group health insurance coverage, the group health plan is deemed to have satisfied the certification requirement under this section if the health insurance issuer offering the coverage provides for such certification in accordance with this section.

(2) Disclosure of Information on Previous Benefits. In the case of an election described in subdivision (c)(2)(B) of this section by a group health plan or health insurance issuer, if the group health plan or health insurance issuer enrolls an individual for coverage under the group health plan and the individual provides a certification of coverage of the individual under subdivision (e)(1) of this section:

(A) Upon request of the group health plan or health insurance issuer, the entity which issued the certification provided by the individual shall promptly disclose to the requesting group health plan or issuer information on coverage of classes and categories of health benefits available under the entity's plan or coverage; and

(B) The entity may charge the requesting group health plan or health insurance issuer for the reasonable cost of disclosing the information.

(f) Special Enrollment Periods.

(1) Individuals Losing Other Coverage. A group health plan and a health insurance issuer offering group health insurance coverage in connection with a group health plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the group health plan or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms to enroll for coverage under the terms of the group health plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or health insurance issuer if applicable required such a statement at that time and provided the employee with notice of the requirement and the consequences of such a requirement at that time;

(C) The employee's or dependent's coverage described in subdivision (f)(1)(A) of this section:

(i) Was under a COBRA continuation provision and the coverage under such a provision was exhausted; or

(ii) Was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage including loss as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment or employer contributions toward the coverage were terminated; and

(D) Under the terms of the group health plan, the employee requests the enrollment not later than thirty (30) days after the date of exhaustion of coverage described in subdivision (f)(1)(C)(i) of this section or termination of coverage or employer contribution described in subdivision (f)(1)(C)(ii) of this section.

(2) For Dependent Beneficiaries.

(A) In General. If:

(i) A group health plan makes coverage available with respect to a dependent of an individual;

(ii) The individual is a participant under the group health plan or has met any waiting period applicable to becoming a participant under the group health plan and is eligible to be enrolled under the group health plan but for that individual's failure to enroll during a previous enrollment period; and

(iii) A person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

then the enrollment period described in subdivision (f)(2)(B) of this section shall be provided, during which the person, or, if not otherwise

enrolled, the individual, may be enrolled under the group health plan as a dependent of the individual and, in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

(B) Dependent Special Enrollment Period. A dependent special enrollment period under subdivision (f)(2)(A) of this section shall be a period of not less than thirty (30) days and shall begin on the later of:

(i) The date dependent coverage is made available; or

(ii) The date of the marriage, birth, or adoption or placement for adoption, as the case may be, described in subdivision (f)(2)(A)(iii) of this section.

(C) No Waiting Period. If an individual seeks to enroll a dependent during the first thirty (30) days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

(i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) In the case of a dependent's birth, as of the date of the birth; or

(iii) In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(g) Use of Affiliation Period by Health Maintenance Organizations as Alternative to Preexisting Condition Exclusion.

(1) In General. In the case of a group health plan that offers medical care through coverage offered by a health maintenance organization, the group health plan may provide for an affiliation period with respect to coverage through the health maintenance organization only if:

(A) No preexisting condition exclusion is imposed with respect to coverage through the health maintenance organization;

(B) The affiliation period is applied uniformly without regard to any health status-related factors; and

(C) The affiliation period does not exceed two (2) months or three (3) months in the case of a late enrollee.

(2) Affiliation Period.

(A) Affiliation Period. The health maintenance organization is not required to provide healthcare services or benefits during the affiliation period, and no premium shall be charged to the participant or beneficiary for any coverage during the affiliation period.

(B) Beginning. The affiliation period shall begin on the enrollment date.

(C) Runs Concurrently with Waiting Periods. An affiliation period under a group health plan shall run concurrently with any waiting period under the group health plan.

(3) Alternative Methods. A health maintenance organization described in subdivision (g)(1) of this section may use alternative methods from those described in subdivision (g)(1) of this section to address adverse selection as approved by the Insurance Commissioner.

History. Acts 1997, No. 997, § 1; 2019, No. 315, § 2747.

Amendments. The 2019 amendment substituted "rules" for "regulations" in (c)(2)(B)(i).

23-86-310. Excepted benefits — Definition.

For purposes of this section, the term "excepted benefits" means benefits under one (1) or more, or any combination thereof, of the following:

(1) Benefits not subject to requirements:

(A) Coverage only for accident or disability income insurance, or any combination thereof;

(B) Coverage issued as a supplement to liability insurance;

(C) Liability insurance, including general liability insurance and automobile liability insurance;

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for on-site medical clinics;

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(2) Benefits not subject to requirements if offered separately:

(A) Limited scope dental or vision benefits;

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(C) Such other similar, limited benefits as specified in rules;

(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits:

(A) Coverage only for a specified disease or illness; and

(B) Hospital indemnity or other fixed indemnity insurance; and

(4) Benefits not subject to requirements if offered as a separate insurance policy. Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under United States Code Title 10, Chapter 55, and similar supplemental coverage provided to coverage under a group health plan.

History. Acts 1997, No. 997, § 1; 2019, No. 315, § 2748.

Amendments. The 2019 amendment substituted "rules" for "regulations" in (2)(C).

23-86-311. Guaranteed renewability of coverage for employers in the group market.

(a) In General. Except as provided in this section, if a health insurance issuer offers health insurance coverage in the small-group market or the large-group market in connection with a group health plan, the issuer must renew or continue in force that coverage at the option of the plan sponsor.

(b) General Exceptions. A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the small-group market or the large-group market based only on one (1) or more of the following:

(1) Nonpayment of Premiums. The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the health insurance issuer has not received timely premium payments;

(2) Fraud. The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) Violation of Participation or Contribution Rules. The plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules in the case of the small-group market or pursuant to applicable Arkansas law in the case of the large-group market;

(4) Termination of Coverage. The issuer is ceasing to offer coverage in such a market in accordance with subsection (c) of this section and applicable state law;

(5) Movement Outside Service Area. In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with the network plan who lives, resides, or works in the service area of the health insurance issuer, or in the area for which the health insurance issuer is authorized to do business, and, in the case of the small-group market, the health insurance issuer would deny enrollment with respect to the network plan under § 23-86-312(c)(1)(A);

(6) Association Membership Ceases. In the case of health insurance coverage that is made available in the small-group market or the large-group market, as the case may be, only through one (1) or more bona fide associations, the membership of an employer in the bona fide association on the basis of which the coverage is provided ceases but only if the coverage is terminated under this subdivision (b)(6) uniformly without regard to any health status-related factor relating to any covered individual;

(7)(A) If a health insurance issuer nonrenews or discontinues group health insurance coverage under subdivision (b)(1) of this section, the health insurance issuer shall provide written notice to the individual employees insured under the group health plan so that the employees will have no fewer than fourteen (14) days to acquire alternative health coverage without loss of creditable coverage due to a break in coverage, as provided under § 23-86-304(d)(4).

(B) The Insurance Commissioner shall determine by rule the form, content, and timing of the notice under subdivision (b)(7)(A) of this section.

(c) Requirements for Uniform Termination of Coverage.

(1) Particular Type of Coverage Not Offered. In any case in which a health insurance issuer decides to discontinue offering a particular type

of group health insurance coverage offered in the small-group market or the large-group market, coverage of this type may be discontinued by the health insurance issuer in accordance with Arkansas law in such a market only if:

(A) The health insurance issuer provides notice to each plan sponsor provided coverage of this type in such a market and participants and beneficiaries covered under that coverage of the discontinuation at least ninety (90) days prior to the date of the discontinuation of the coverage;

(B) The health insurance issuer offers to each plan sponsor provided coverage of this type in such a market the option to purchase all or, in the case of the large-group market, any other health insurance coverage currently being offered by the health insurance issuer to a group health plan in such a market; and

(C) In exercising the option to discontinue coverage of this type and in offering the option of coverage under subdivision (c)(1)(B) of this section, the health insurance issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for that coverage.

(2) Discontinuance of All Coverage.

(A) In General. In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the small-group market or the large-group market, or both markets in this state, health insurance coverage may be discontinued by the health insurance issuer only in accordance with Arkansas law and if:

(i) The health insurance issuer provides notice to the Insurance Commissioner and to each plan sponsor and participants and beneficiaries covered under the coverage of the discontinuation at least one hundred eighty (180) days prior to the date of the discontinuation of the coverage; and

(ii) All health insurance issued or delivered for issuance in this state in the market or markets is discontinued and coverage under the health insurance coverage in the market or markets is not renewed.

(B) Prohibition on Market Reentry. In the case of a discontinuation under subdivision (c)(2)(A) of this section in a market, the health insurance issuer may not provide for the issuance of any health insurance coverage in the market in this state during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) Exception for Uniform Modification of Coverage. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan:

(1) In the large-group market; or

(2) In the small-group market if, for coverage that is available in such a market other than only through one (1) or more bona fide

associations, such a modification is consistent with Arkansas law and effective on a uniform basis among group health plans with that product.

(e) Application to Coverage Offered Only Through Associations. In applying this subsection in the case of health insurance coverage that is made available by a health insurance issuer in the small-group market or the large-group market to employers only through one (1) or more associations, a reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such an employer.

History. Acts 1997, No. 997, § 1; 2003, No. 859, § 1; 2019, No. 315, § 2749.

Amendments. The 2019 amendment deleted "or regulation" following "rule" in (b)(7)(B).

Subchapter 4 — Freedom of Choice Among Health Benefit Plans Act of 1999

SECTION.

23-86-404. Optional health benefit plans.

(a) A health maintenance organization may offer and issue health benefit plans that reimburse or arrange for covered healthcare services to covered persons through a limited network plan if:

(1) The health maintenance organization provides itself, or arranges through an insurance company, for an annual option for covered persons to choose a health benefit plan or a point-of-service plan that reimburses or arranges for the covered healthcare services from any healthcare provider qualified to render the covered healthcare services;

(2) The difference in the benefit level of the optional health benefit plan or point-of-service plan shall not exceed twenty-five percent (25%) of the benefit level under the limited benefit plan;

(3) The employer or other group contract holder contracting with the health maintenance organization for a health benefit plan shall provide an equal contribution per covered person regardless of which option the covered person chooses pursuant to the provisions of this subchapter; and

(4) Under the optional health benefit plan or point-of-service plan, the rate of reimbursement for healthcare providers out of the network shall be no higher than the normal and usual and customary rate charged by those out-of-network providers on a regular basis, provided that copayment, coinsurance, and other cost-sharing features may be different for out-of-network providers and in-network providers.

(b)(1) The pricing of the optional health benefit plan or point-of-service plan must provide an expected incurred loss ratio of not less than eighty percent (80%).

(2) The Insurance Commissioner shall promulgate rules as may be necessary to implement the provisions of this subchapter and to ensure

that the price of the option provided in this section bears a reasonable relationship to the costs and benefits of the limited network plan.

(c) This subchapter shall apply to any health benefit plan issued or renewed on or after January 1, 2000.

History. Acts 1999, No. 1469, § 4; 2019, No. 315, § 2750.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (b)(2).

Subchapter 5 — Small Employer Health Insurance Purchasing Group Act of 2001

23-86-502. Definitions.

As used in this subchapter:

(1) "Commissioner" means the Insurance Commissioner;

(2) "Eligible employee" means an employee or individual who is a full-time employee of an eligible employer and is qualified to enroll in a health benefit plan offered through a health insurance purchasing group;

(3) "Eligible employer" means an employer employing no more than one hundred ninety-nine (199) eligible employees;

(4)(A) "Employer", "employee", and "dependent", unless otherwise defined in this section, shall have the meanings applied to the terms with respect to the coverage under the laws of the state relating to the coverage and the issuer.

(B) "Employer" includes a self-employed individual;

(5) "Full time" means employees working at least thirty (30) hours per week for an eligible employer;

(6) "Health benefits plan" means a group plan, group policy, or group contract for healthcare services, issued or delivered by a health insurance purchasing group health carrier, excluding plans, policies, or contracts providing healthcare benefits or healthcare services pursuant to Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., the Public Employee Workers' Compensation Act, § 21-5-601 et seq., and the no-fault medical and hospital benefit requirements under § 23-89-202;

(7) "Health insurance purchasing group" means a health insurance purchasing group meeting the requirements of this subchapter;

(8) "Health insurance purchasing group health carrier" means a health insurer, health maintenance organization, or hospital and medical service organization;

(9) "Health insurer" means an insurer licensed to transact group accident and health insurance in this state;

(10) "Health maintenance organization" means a health maintenance organization as defined in § 23-76-102 that is licensed to transact business in this state as a health maintenance organization under § 23-76-107;

(11) "Hospital and medical service corporation" means a hospital and medical service corporation as defined in § 23-75-101 that is licensed to transact business in this state as a hospital and medical service corporation under § 23-75-107;

(12) "Large group" means a combination of two (2) or more eligible employers belonging to a health insurance purchasing group;

(13) "Member" means an individual enrolled for health benefits coverage in a health insurance purchasing group;

(14) "Purchaser" means an eligible employer that has contracted with a health insurance purchasing group for the purchase of health benefits coverage;

(15)(A)(i) "State-mandated health benefits" means coverages for healthcare services or benefits required by state law or state rules requiring the reimbursement or utilization related to a specific health illness, injury, or condition of the covered person or the inclusion of a specific category of licensed healthcare practitioner to be provided to the covered person in a health benefits plan for a health-related condition of a covered person.

(ii) However, for the purposes of the options provided by this subchapter, state-mandated health benefits that may be excluded, in whole or in part, shall not include any healthcare services or benefits that were mandated by Acts 1971, No. 34.

(B) "State-mandated health benefits" does not mean standard provisions or rights required to be present in a health benefit plan pursuant to state law or state rules unrelated to a specific health illness, injury, or condition of the insured, including, but not limited to, those related to continuation of benefits in § 23-86-114, or entitlement to a conversion policy under § 23-86-115; and

(16) "Total eligible employees" means five hundred (500) or more eligible employees.

History. Acts 2001, No. 925, § 2; 2005, No. 2159, §§ 1, 2; 2019, No. 315, § 2751.

Amendments. The 2019 amendment substituted "rules" for "regulations" in (15)(A)(i) and (15)(B).

23-86-503. Health insurance purchasing group organization requirements.

(a) Each health insurance purchasing group shall be a nonprofit corporation operated under the direction of a board of directors that is composed of five (5) representatives of eligible employers.

(b)(1)(A) Each health insurance purchasing group shall be composed of at least five hundred (500) eligible employees from one (1) or more eligible employers.

(B) However, a health insurance purchasing group shall have twelve (12) months from the time of formation to reach the level of five hundred (500) eligible employees.

(C) At the time of formation, the health insurance purchasing group shall have at least one hundred (100) eligible employees.

(2)(A) Upon the failure of a health insurance purchasing group to maintain the required size restrictions described in this subsection, the health insurance purchasing group shall notify the Insurance Commissioner in writing that the health insurance purchasing group does not comply with the size requirements under subdivision (b)(1) of this section.

(B) The health insurance purchasing group may then continue to operate the health benefits plan for its members but shall comply within sixty (60) calendar days with the size requirements of this section or within a time period as determined by the commissioner.

(C) Upon the failure of the health insurance purchasing group to maintain size requirements as required under this section, after sixty (60) calendar days or after the time period determined by the commissioner, the health insurance purchasing group may then be terminated following notice and hearing before the commissioner.

(c)(1)(A) Subject to the provisions of this subchapter, a health insurance purchasing group shall permit any eligible employer that meets the membership requirements of the health insurance purchasing group to contract with the health insurance purchasing group for the purchase of a health benefits plan for its eligible employees and dependents of those eligible employees.

(B) The health insurance purchasing group may not vary conditions of eligibility, including premium rates and membership fees, for any employer meeting the membership requirements of the health insurance purchasing group, nor may it vary conditions of eligibility for any employee to qualify for a health insurance purchasing group health benefits plan offered to the eligible employer by the health insurance purchasing group.

(2)(A) A contract shall provide that the purchaser agrees not to obtain or sponsor a health benefits plan on behalf of any eligible employees and their dependents other than through the health insurance purchasing group.

(B) Subdivision (c)(2)(A) of this section shall not be construed to apply to an eligible individual who resides in an area for which no coverage is offered by a health insurance purchasing group health carrier.

(3)(A)(i) Under rules established to carry out this subchapter with respect to an eligible employer that has a purchaser contract with a health insurance purchasing group, individuals who are eligible employees of an eligible employer may enroll for a health benefits plan offered by a health insurance purchasing group health carrier.

(ii) This may include coverage for dependents of the enrolling employees if this coverage is offered.

(B) The employees may enroll for health benefits provided through their employer's contract with a health insurance purchasing group.

(4) A health insurance purchasing group shall not deny enrollment as a member to an individual who is an eligible employee or dependent of an employee qualified to be enrolled based on health status-related factors except as may be permitted by law.

(5) In the case of members enrolled in a health benefits plan offered by a health insurance purchasing group health carrier, the health insurance purchasing group shall provide for an annual open enrollment period of thirty (30) calendar days during which the members may change the coverage option in which the members are enrolled.

(6)(A) Nothing in this subsection shall preclude a health insurance purchasing group from establishing rules of employee eligibility for enrollment and reenrollment of members during the annual open enrollment period under subdivision (c)(5) of this section.

(B) The rules shall be applied consistently to all purchasers and members within the health insurance purchasing group and shall not be based in any manner on health status-related factors and shall not conflict with sections of this subchapter.

(d)(1) Each health insurance purchasing group shall annually file with the commissioner a description of its:

(A) Plan of operation, including each of the products it intends to sell;

(B) Marketing methods and materials; and

(C) Membership and disclosure requirements or other information as required by the commissioner through rules.

(2) The plan of operation filed with the commissioner by the health insurance purchasing group pursuant to this subsection shall be deemed approved sixty (60) calendar days after the date of filing unless additional time is requested by the commissioner to review the plan.

(e) Each health insurance purchasing group shall be considered a large group for purposes of application of the Arkansas Insurance Code to the activities and health benefit plans of the health insurance purchasing group unless stated otherwise in this subchapter.

(f) No purchaser, health insurance purchasing group, health maintenance organization, or health insurer providing coverage to a health insurance purchasing group shall be subject to any provisions in § 26-57-601 et seq. for insurance premiums collected for health benefit plans of health insurance purchasing groups.

History. Acts 2001, No. 925, § 3; 2003, No. 1358, § 1; 2019, No. 315, § 2752.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (d)(1)(C).

23-86-504. Health insurance purchasing group health benefits coverage requirements.

(a)(1) In conjunction with a health insurance purchasing group health carrier, each health insurance purchasing group that offers health benefit plans to small employers as defined by § 23-86-303 shall guarantee the availability of coverage to small employers as required by § 23-86-312(a).

(2) All health benefit plans provided through a health insurance purchasing group shall be offered at rates, including employer's and employees' share, on a policy-specific or product-specific basis that may vary only as permitted under law.

(b) Subject to subsection (c) of this section, a health insurance purchasing group shall not offer a health benefits plan that unfairly discriminates against eligible employees.

(c) Nothing in this subchapter shall be construed as requiring a health insurance purchasing group health carrier to provide coverage outside the service area of the insurer or organization.

(d) Each health insurance purchasing group shall provide a health benefits plan only through contracts with health insurance purchasing group health carriers and shall not assume insurance risk with respect to the coverage.

(e) Except as provided in this subchapter, the health insurance purchasing group may provide a health benefits plan in whole or in part, not subject to state-mandated health benefits, except those required in the Arkansas Health Insurance Portability and Accountability Act of 1997, § 23-86-301 et seq.

(f) The health insurance purchasing group shall offer at least two (2) types of plans including one (1) plan providing a choice of deductibles with state-mandated health benefits.

(g) The health insurance purchasing group may also offer a health benefits plan not subject to state-mandated health benefits that does not contain standard provisions or rights required to be present in a health benefits plan pursuant to law or regulations unrelated to a specific health illness, injury, or condition of the insured, for the provisions as may be determined by rules of the Insurance Commissioner.

(h)(1) Every health benefits plan offered through a health insurance purchasing group shall:

(A) Be underwritten by a health insurance purchasing group health carrier that:

(i) Is licensed or otherwise regulated under state law;

(ii) Meets all applicable state standards relating to consumer protection, including, but not limited to, state solvency and market conduct; and

(iii) Offers the coverage under a contract with the health insurance purchasing group;

(B) Be approved or otherwise permitted to be offered under law;

(C) Provide full portability of creditable coverage for individuals who remain members of the same health insurance purchasing group, notwithstanding that they change the eligible employer through which they are members; and

(D) Comply with the provisions of the Arkansas Insurance Code in their sales and solicitation of insurance, including, but not limited to, the Trade Practices Act, § 23-66-201 et seq., and the requirements of §§ 23-64-102(1) and 23-64-201 that all insurance must be sold by an agent licensed by the State Insurance Department.

(2)(A) Any agent referenced in subdivision (h)(1)(D) of this section shall be required to obtain at least two (2) hours of continuing education on a health insurance purchasing group or the plans the health insurance purchasing group sponsors each year, or both.

(B) The requirement in subdivision (h)(2)(A) of this section shall be considered as part of the continuing education requirements provided in § 23-64-301 and shall not preempt or conflict with the provision.

(i) A health insurance purchasing group shall be exempt from the requirements of § 23-86-201 et seq.

(j) Nothing in this subchapter shall be construed as precluding a health insurance purchasing group health carrier from offering a health benefits plan through a health insurance purchasing group by establishing premium discounts for members or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention, so long as the programs are agreed to in advance by the health insurance purchasing group and comply with all other provisions of this subchapter and do not discriminate among similarly situated members.

History. Acts 2001, No. 925, § 4; 2003, No. 1358, § 2; 2005, No. 2159, § 3; 2019, No. 315, § 2753.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (g).

23-86-505. Notice requirements.

In each sale of a health benefits plan to a proposed eligible employer through a health insurance purchasing group in which the health insurance purchasing group offers an option to an eligible employer to obtain a health benefits plan that, either in whole or in part, does not provide state-mandated health benefits or does not contain standard provisions as may be determined by rules of the Insurance Commissioner, the health insurance purchasing group, after the employer has selected its health benefit plan, shall provide to each eligible employee of the employer a written notice, in a form and manner as prescribed by rule promulgated by the commissioner, that one (1) or more mandated benefits are not included in the health benefit plan.

History. Acts 2001, No. 925, § 5; 2003, No. 1358, § 3; 2019, No. 315, § 2754.
Amendments. The 2019 amendment deleted "and regulations" following "rules" in the text.

23-86-507. Filing and form filing requirements.

Each health insurance purchasing group shall file forms as may be described by rules of the Insurance Commissioner.

History. Acts 2001, No. 925, § 7; 2019, No. 315, § 2755.
Amendments. The 2019 amendment deleted "and regulations" following "rules" in the text.

23-86-511. Rules.

The Insurance Commissioner may promulgate rules necessary to implement the provisions of this subchapter.

History. Acts 2001, No. 925, § 11; 2019, No. 315, § 2756.
Amendments. The 2019 amendment substituted "rules" for "regulations" in the section heading and the text.

CHAPTER 87

MODEL ACT FOR THE REGULATION OF CREDIT LIFE INSURANCE AND CREDIT DISABILITY INSURANCE

SECTION.

23-87-117. Compensation limited.

(a)(1) In order to assure that the premium rates charged or to be charged for credit life insurance or credit disability insurance are reasonable in relation to benefits provided, the Insurance Commissioner, after due notice and hearing, may issue rules establishing the maximum compensation payable to an agent, a broker, or a creditor or any affiliate, associate, subsidiary, director, officer, employee, or other representative of or for the creditor for writing or handling the insurance, including commission, dividends, premium adjustments, policy writing fees, underwriting gain, or any compensation or remuneration in whatever form.

(2) An insurer may disclose the amount of commission or compensation payable to an agent, broker, or creditor under this section.

(b) Provided, the term "compensation" as defined and used in this section shall not be deemed to include reinsurance premiums paid to, or underwriting profits generated by, an insurer or reinsurer owned by, controlled by, or under common control with a credit insurer, an agent, broker, creditor, group of creditors, or any affiliate, associate, subsidiary, director, officer, employee, or other representative of, or for such a credit insurer, creditor, or group of creditors, on accounts in existence

with such an insurer or reinsurer on January 17, 1989, that have been registered with the commissioner within twenty (20) days of July 3, 1989, in accordance with pertinent rules promulgated by the commissioner.

(c) Provided further, any and all payments to all direct and indirect successors in interests whether through purchase, gift, devise, or otherwise, related to all accounts registered under this section shall also not be deemed compensation.

History. Acts 1959, No. 148, § 441; 1985, No. 950, § 1; A.S.A. 1947, § 66-3815; Acts 1989, No. 177, § 1; 1989, No. 843, § 1; 2003, No. 1794, § 6; 2019, No. 315, §§ 2757, 2758.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (a)(1), and in (b).

23-87-118. Enforcement.

(a) After notice and hearing, the Insurance Commissioner may issue such rules as the commissioner deems appropriate for the supervision of this chapter.

(b)(1) Whenever the commissioner finds that there has been a violation of this chapter or any rules issued pursuant thereto, and after written notice thereof and hearing given to the insurer or other person licensed by the commissioner, the commissioner shall set forth the details of his or her findings together with an order for compliance by a specified date.

(2) The order shall be binding on the insurer and other person licensed by the commissioner on the date specified unless sooner withdrawn by the commissioner or a stay thereof has been ordered by a court of competent jurisdiction.

History. Acts 1959, No. 148, § 442; A.S.A. 1947, § 66-3816; Acts 2019, No. 315, § 2759.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (a).